CMP
Business Media

Chemist&Druggist
The Newsweekly for Pharmacy

C&D

5 February 2005

Co-proxamol to go as health risk too great

Pharmacy chains up market share, say DoH stats

NPA to meet minister over oxygen contract

Hot topics from the tropics, Numark style

AS SEEN ON T.V.

This tiny Dulco-lax® Perle is now the big star of its own £1.8 million TV campaign, so make sure you stock up now. Offering the convenience of flexible dosing, Dulco-lax Perles® are a discreet way to help restart your customers' natural rhythm. Stock up now: the word is out!

sodium picosulfate

www.dulcolax.co.uk

Help restart their natural rhythm

Dulco-lax Perles: product information (sodium picosulfate) **Active ingredient:** Gelatin capsule containing 2.5mg sodium picosulfate as monohydrate. **Indication:** Short term relief of constipation **Dose:** Adults and children over 10 years: two to four capsules at night. Children 4-10 years should not take Dulco-lax Perles without medical advice. Children 4-10 years: One to two capsules at night. Children under 4 years: not recommended. **Contraindications:** Intestinal obstruction, ileus, acute surgical abdominal conditions like acute appendicitis, acute inflammatory bowel diseases, hypersensitivity to sodium picosulfate or other component, and in severe dehydration. **Precautions:** Not to be taken on a continuous daily basis for long periods. Prolonged excessive use may lead to electrolyte imbalance and hypokalaemia, and may precipitate onset of rebound constipation. Diuretics or adreno-corticosteroids may increase the risk of electrolyte imbalance. Antibiotics may reduce laxative action. Dulco-lax Perles should not be used in pregnancy, especially the first trimester, unless the expected benefit is thought to outweigh any possible risk to the foetus. Not recommended for breast-feeding mothers. **Side-effects:** Abdominal discomfort (abdominal pain or cramps), diarrhoea, allergic reactions, angio-oedema, and skin reactions have been reported. **Product Licence Holder:** Boehringer Ingelheim Ltd, Ellesfield Avenue, Bracknell, Berkshire, RG12 8YS. **Presentation & retail price:** Dulco-lax Perles 50 capsules £4.59 PL00015/0254 (P) or 20 capsules £2.99 PL00015/0254 (GSL). For full product information please see summary of product characteristics. Prepared January 2004.

Editor
Charles Gladwin, *MRPharmS*
News Editor
Gary Paragpuri, *MRPharmS*
Clinical Editor
Fiona Salvage, *MRSC*
Contributing Editor
Adrienne de Mont, *MRPharmS*
Marketing Editor
Sarah Thackray
News Reporter
Asha Fowell, *MRPharmS*
Reporter
Vikki Miller
Production Editor
Fay Jones, *BA*
Group Art Editor
Richard Coombe
Editorial Secretary
Jan Powis
Editorial (tel): [illegible]
(fax): 0173[illegible]
chemdrug@[illegible]
Price List
[illegible]
Darren Larkin ([illegible] Manager)
Maria [illegible]
Price List (tel): [illegible] 377407
(fax): 0173[illegible]
Group Sales Manager
Quentin Soldan
pharmacysales@[illegible]
Sales Manager
Mark Walley
Classified Executive
Debra Thackeray, *BA*
Advertisement Secretary
Elaine Steele
Advertising (tel): [illegible]
(fax): 01732 [illegible]
Projects and Price Service Manager
Patrick [illegible], *MRPharmS*
Pharmacy Projects
Mary Preuble
01732 377264
Production
Katrina Avery
Publishing Director
Jim Jones

Published Saturdays by
CMP Information Ltd,
Sovereign Way,
Tonbridge, Kent TN9 1RW

C&D on the internet at
http://www.dotpharmacy.com/

Subscriptions: (Home) £173 per annum, (Overseas & Eire) $412 per annum. Single copies C&D £3.50 (postage extra)
Extra Price List for subscribers: £16 per single copy; for non-subscribers: £55 per single copy. Subscription plus additional Price List: UK £173 plus £120, overseas: $412 plus $205

Circulation and subscription:
CMP Information Ltd, Tower House, Sovereign Park, Lathkill St, Market Harborough, Leics LE16 9EF
Telephone: 01858 438809
Fax: 01858 434958

Refunds on cancelled subscriptions will only be provided at the publisher's discretion, unless specifically guaranteed within the terms of subscription offer

The editorial photos used are courtesy of the suppliers whose products they feature

PPA

ABC

CMP
United Business Media

www.dotpharmacy.com

C&D

Chemist & Druggist

[illegible]

Volume 263 No 6480
First published
September 15, 1859
ISSN 0009-3033

News

Co-proxamol to be withdrawn 4
The phased withdrawal of co-proxamol follows a recent Committee on Safety of Medicines review of the painkiller which found no indications or patient groups where its efficacy outweighed the risks of toxicity

NPA seeks oxygen talks 5
NPA chief executive John D'Arcy (left) believes the full audit, demanded by BOC of oxygen cylinders that have been issued by community pharmacists, is virtually impossible and he says NPA will resist the idea of pharmacists "being left holding the baby"

Clinical roles could be saving grace 6
In response to the latest DoH pharmacy statistics, NPA chief executive John D'Arcy has said that the clinical roles that the new pharmacy contract will bring could be the thing to save the independent sector

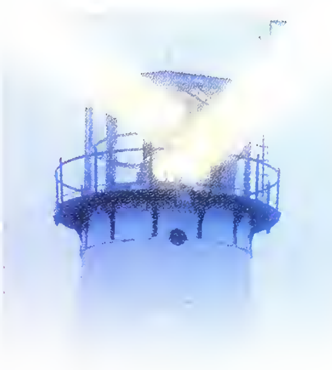
Reid launches GMC review 8
The way the General Medical Council revalidates and ensures doctors are fit to practise is to be reviewed. The DoH says this will not affect the RPSGB as it is a regulator and professional body, not a representative body

Signed, sealed, delivered... 9
As the April 1 deadline approaches, Adrienne de Mont finds out how ready pharmacy software suppliers are likely to be

Regulars

Pharmacyupdate

Tailoring drugs 17
Professor Danny Burke concludes his series on the cytochrome P450 enzymes and how knowledge of them influences treatment choice



26

Features

Ray of hope 26
David Morgan caused a stir last autumn with his controversial views on locuming. Here he looks to the future and how things might be better

Paradise gained? 24
Charles Gladwin reports from the Numark conference in Mauritius

A pharmacy vision 28
A round table discussion about the new contract is being issued on CD-Rom with this week's *C&D*

Co-proxamol to be withdrawn

by Asha Fowells

The Medicines and Healthcare products Regulatory Agency has announced a phased withdrawal of co-proxamol.

The decision follows a recent Committee on Safety of Medicines review into the risks and benefits of the painkiller (*C&D, July 10, p6*). The CSM concluded there were no indications or patient groups where the analgesic's efficacy outweighed the risks of toxicity.

One of the main concerns was the risk of overdose. The painkiller is the second most common prescription drug associated with fatal overdoses, and around 300 to 400 people die each year as a result of accidentally or deliberately taking too many co-proxamol tablets. In addition, the drug interacts with alcohol to lower the threshold for fatal toxicity.

Pending its withdrawal over the next six to 12 months, the CSM has issued interim co-proxamol prescribing advice. It says co-proxamol should not be started in new patients and only used where first line analgesics are ineffective or inappropriate. Also alcohol dependent patients should not be given co-proxamol.

Patients currently taking co-proxamol can continue to do so but should have their treatment reviewed at their next GP visit.

RPSGB director of practice and quality improvement David Pruce criticised the MHRA for not informing healthcare professionals before making the withdrawal announcement.

"Co-proxamol is widely prescribed and the news of its withdrawal has inevitably led to concerns among some patients...it should have been possible for healthcare professionals to have been fully briefed about the withdrawal before it was announced to the public. This would have allowed pharmacists and others to explain the situation to their patients and to offer reassurance," he said.

Arthritis Care acting chief executive Neil Betteridge described it as "bad news for people with arthritis", saying that alternatives such as co-codamol caused constipation and would not be suitable for all.

Mr Betteridge believes that a stringent package of prescribing advice, covering changes and other warnings, could limit the risks of co-proxamol being misused.

But MHRA chairman Sir Alasdair Breckenridge said measures to strengthen the labelling of co-proxamol had been ineffective in reducing the high fatality rate.

Labour MP says drug labelling is 'ambiguous'

Current labelling of pharmaceuticals that act on the brain and central nervous system is "ambiguous and unhelpful", Labour MP Andrew Dismore said in the Commons this week.

He introduced a backbench bill to force manufacturers to display a red warning triangle on drugs which, for example, could impair drivers' judgement. Mr Dismore said existing pharmaceutical warnings were inadequate.

Although pharmacy labels warn against drowsiness, Mr Dismore added: "By the time someone feels drowsy, it is already too late, as the safe limits will have been exceeded.

"My bill would require the external packaging of those medicines known to have an effect on judgement to be prominently marked. I propose a red triangle, meaning quite simply that the 'use of this medication could seriously impair your judgement'."

He said the benzodiazepines, tricyclic antidepressants, and antihistamines would come under this category.

"A red triangle marking would stand as an unambiguous warning that the ability to drive or work safely might well be impaired on taking the drug." **CB**

Welsh health minister reiterates OFT rejection

Fears that pressure from England's Department of Trade and Industry could lead to Wales adopting the OFT proposals on freeing up control of entry for pharmaceutical services have been firmly rejected by the new health minister.

In a formal reply to Liberal Democrat health spokeswoman Kirsty Williams, Dr Brian Gibbons confirmed that First Minister Rhodri Morgan had been "kept informed" by the DTI about changes in England, but added: "We have stressed that the recommendations of the OFT report have not been accepted in Wales." Dr Gibbons, who replaced the long-serving Jane Hutt, is seen as a devolution-radical in Wales, and he has quickly made clear that Wales is sticking to its guns.

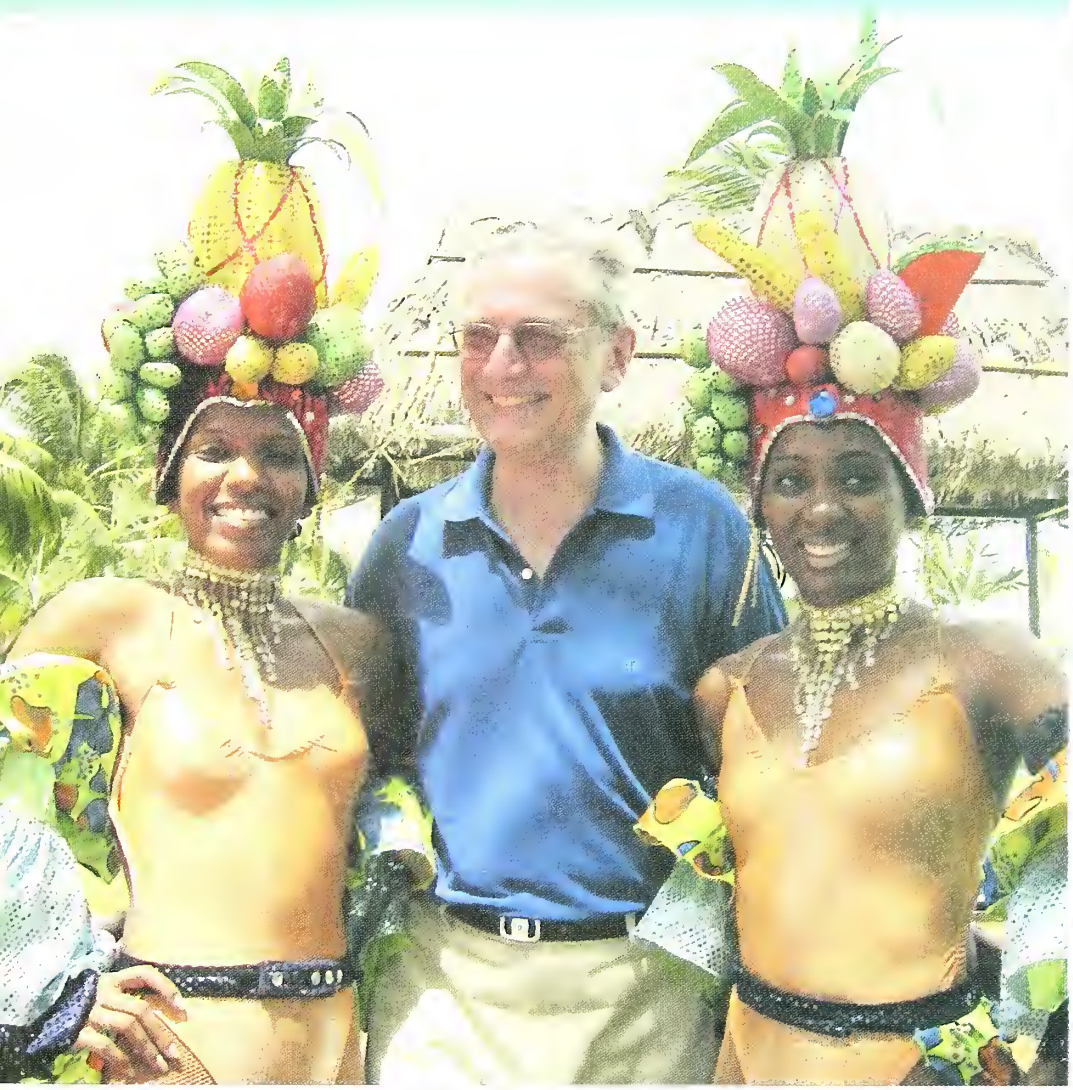
Asked whether he intended to reconsider control of entry in Wales, Dr Gibbons said the First Minister had agreed to consult stakeholders on proposals to make regulatory changes which could streamline the applications, decisions and appeals procedures. "However, the basic control of entry regulation will remain the same," added Dr Gibbons.

In an addendum to PSNC's contract book published last year, Community Pharmacy Wales, the negotiating body for contractors, had said it was aware that the First Minister had agreed to reconsider control of entry in Wales in correspondence with the DTI secretary for state.

However, CPW chief executive Peter Haydn Jones now confirmed that the OFT's proposals for control of entry had been "robustly rejected in Wales and the status quo remains in place".

Proof that no change is contemplated lies in the new community pharmacy contract regulations that were expected to be debated by the Assembly's health committee this Wednesday and which exclude all mention of the subject; it is understood that the English regulations, shortly to be handled by Parliament, will in contrast include detail about new OFT-style entry regulations.

The new Welsh position is almost certain to be consolidated when the regulations are sent to a 60-member plenary session this spring for debate and adoption. **CB**



NPA seeks oxygen talks with health minister

by Adrienne de Mont

NPA representatives are to meet the health minister again to try to resolve problems with the new arrangements for oxygen supply.

BOC has written to pharmacy contractors asking them to check the whereabouts of the oxygen cylinders they have issued and to pay for any that are "lost".

"You are requested to conduct a full audit of BOC cylinders for which you are responsible, whether they are in current patients' homes, past patients' homes or your own premises," says the letter.

But NPA chief executive John D'Arcy believes such stock-taking is virtually impossible.

"Once the cylinder leaves the pharmacy, it is largely out of the pharmacist's control. There is no proper audit trail so we are very concerned about the plight of contractors," he said.

"We will resist the idea of pharmacists being left holding the baby."

The NPA is to meet health minister Rosie Winterton next week and is also seeking an urgent meeting with BOC.

The company's reconciliation of customers' accounts has been extended until April and BOC will continue to supply pharmacies until September at least.

The NPA Board is also concerned that patients might have difficulty obtaining supplies if the pharmacy service has to run down in the months before the new regional oxygen contractors take over in England and Wales in October this year. In addition, there are doubts whether these contractors will be able to fulfil a 24-hour service.

Mr D'Arcy thinks there should be facilities for pharmacies to make emergency supplies if necessary. Once introduced, the new service should be reviewed to see if it works adequately. If not, oxygen supply should go back to pharmacies where it has worked well for many years, he said.

Inbrief

BPC medals

Nominations are being sought for the two research awards to be presented at this year's British Pharmaceutical Conference.

The *C&D*-sponsored Practice Research Medal recognises individuals aged up to 45 years who have made a significant contribution to pharmacy practice research. In addition, applications are being invited for the 2005 Conference Science Medal from scientists aged below 35 years with a proven record of independent research.

In addition to receiving cheques, both winners will be invited to deliver a lecture at BPC 2005.

ZD update

APO-Go 5mg per 5ml Solution for Infusion pre-filled syringe (Brittania) has been added to the Zero Discount List A for the March 2005 *Drug Tariff*, PSNC has announced.

Drug recall

Crescent Pharmaceuticals is recalling a batch of bendrofluazide 2.5mg tablets as it has been found to contain warfarin 3mg tablets.

Pharmacists are asked to quarantine all Crescent livery packs of bendrofluazide 2.5mg tablets with batch no 404340 and an expiry date of April 2006, and return them to their supplier for credit. It adds that attempts should be made to recover tablets from patients.

The MHRA says patients are advised to cease taking the tablets and to consult their GP. "Although it is unlikely that adverse effects will be experienced, you should contact your doctor if there is any evidence of unusual bleeding," it adds.

For more information:

Crescent Pharmaceuticals

Tel: 07799 666 373

Pharmacist Nos

The number of pharmacists registering as non-practising has increased to 5,212, a rise of over 700 in one week, the RPSGB announced on Tuesday.

To date, 38,408 pharmacists have registered with the RPSGB, with 86.4 per cent as practising and 13.6 per cent as non-practising.

C&D understands that about 2,000 pharmacists have resigned but the Society was unable to confirm this. It said further figures would "be available in April". In 2004 there were 46,783 pharmacists registered with the RPSGB.

Newsdesk:
01732 377688

CONTRACT

Clinical roles could be saving grace for sector

The clinical roles that the new pharmacy contract will bring could be the thing to save the independent pharmacy sector, NPA chief executive John D'Arcy has said in response to the latest DoH pharmacy statistics.

These reveal that multiples now outnumber independents both by number and by share of trade.

The DoH's *Statistical Bulletin for General Pharmaceutical Services in England and Wales 1994-95 to 2003-04* states that the proportion of pharmacies in chains of more than five has increased from just over 33 per cent to 53 per cent of all contractor pharmacies.

Moreover, over the decade to 2003-04, the number of multiples dispensing over 10,000 items a month has increased by over 300 per cent – compared to the overall 273 per cent growth in this sector of the market – consolidating a growing share of the market for pharmacies dispensing over 4,000 items a month.

However, Mr D'Arcy does not believe that multiples can sustain this level of growth. Noting that the total number of pharmacies under contract with PCTs/LHBs in England and Wales has increased by only 10 over the year to March 31, 2004, to 10,462, the NPA chief believes that the UK market, like that in the USA, may settle at a 60:40 split in favour of the multiples, limited by factors such as a finite pool of acquisition targets and the long-term consequences of the new control of entry regulations.

Furthermore, the new clinical roles could be a key way for independents to position themselves as community healthcare providers. He says: "Independents have coped with intense competition in the past. They have the ability to move quickly when they need to." **AC**

Key points in 10-year statistics

- During 2003-04, pharmacists in England and Wales received 660.9 million dispensing fees, an increase of 42.9 per cent over the decade to 2003-04
- Over the decade, the proportion of pharmacies dispensing more than 10,000 items a month has increased from 1.7 per cent to 6.3 per cent
- On March 31, 2004, 59 per cent of pharmacies were being paid to provide oxygen services
- 2,911 pharmacies in England and Wales were receiving payment for providing advice to residential and/or nursing homes. On average, each provides advice to four homes
- The mean number of prescription items dispensed per pharmacy was 5,141 per month
- An equal number of pharmacies (25 per cent) dispense fewer than 3,110 prescriptions a month or more than 6,580 per month
- In 2003-04, 805 pharmacies (7 per cent of total) dispensed fewer than 1,600 items a month, 31 per cent of which dispense fewer than 1,100 items a month.

MEDICINES

P&G seeks GSL switch for Pepto-Bismol

Proctor & Gamble has applied to the MHRA to have Pepto-Bismol reclassified as a GSL product.

The company says that the product has been a P medicine in the UK for 25 years with no evidence of misuse and with a small hazard to health.

The GSL packs – 120ml, 240ml 480ml – will be indicated for the treatment of stomach upsets, indigestion, heartburn, nausea, and diarrhoea, in adults and children 16 years and over.

The MHRA has called for warning labels on prolonged use and the use of oral rehydration treatment for diarrhoea to be included.

Comments should be posted to Amanda Lawrence, Room 14-152, Market Towers, 1 Nine Elms Lane, London SW8 5NQ, or to *Amanda.Lawrence@mhra.gsi.gov.uk* by February 25. **GP**

A [illegible] to take cancer prevention information in Glasgow [illegible] month. The [illegible] screen, [illegible] developed by NHS Greater Glasgow and is supported by a Lottery grant. Pictured at [illegible] Pharmacy, [illegible] Street with Iain [illegible], left, [illegible] general manager, and David Lorimer, pharmacy manager.

MEDICINES

MHRA posts ADRs online

All adverse reactions to every licensed drug are being posted online for patients to read by the Post-Licensing Division of the Medicines and Healthcare products Regulatory Agency.

This follows MHRA chairman Sir Alasdair Breckenridge's admission to a Commons health select committee that the MHRA had not released important information in the past.

Sir Alasdair said the Yellow Card system had been reformed and, from the middle of this year, when the MHRA gives a licence, it will issue what it calls a 'United Kingdom product public assessment report', which will give data of all clinical trials. **CB**

Inbrief

Kava-kava review

The MHRA has issued a consultation document on whether the ban on kava-kava in unlicensed medicines should be lifted.

Following the 2003 ban, the MHRA committed to a review of available evidence after two years. This consultation is now live and comments can be submitted to Judith Thompson, MHRA, Herbal Policy Unit, Room 16-161, Market Towers, Nine Elms Lane, London SW8 5NQ by April 30, 2005.

Lorazepam supply

Genus Pharmaceuticals says it has increased its manufacturing capacity for lorazepam tablets in light of last week's lorazepam recall issued by IVAX Pharmaceuticals. Genus expects "no problems getting supplies from any of the normal pharmacy channels".

NPA training

The NPA has launched a distance learning training course to help pharmacists provide advanced services under the new contract.

The training – *From Prescription to Patient* – incorporates a competency assessment, which will be carried out by Reading University, and is sponsored by Pfizer Consumer Healthcare. The NPA said members would be informed of the costs when they inquired about the course.

This is the second training package on advanced services of the new pharmacy contract. It follows C&D's *Skills for the Future* package, published in association with PSNC and Medway School of Pharmacy, and supported by an educational grant from GSK Plus.

The competency assessment for *Skills for the Future*, which has about 3,000 participants, costs £60.

- The NPA has called an election to fill the vacancy created by Graham Phillips' resignation from its board. Voting closes on March 11; the result will be known on March 14.

Questiontime

This week's question:

A Labour MP proposed a red triangle on drug labels to highlight the risk of drowsiness when driving. Is this

- A good idea
- Too confusing for the patient
- Wrong – they should get that advice when the drug is dispensed

You have until noon on February 8 to vote at *www.dotpharmacy.com*. We will publish the results in *C&D* on February 12.

Prescribing Information: Unguentum M is an ambiphilic topical preparation with emollient properties, which contains the high lipid content of an ointment but also has the water miscible characteristics of a cream. Contains: Purified water, white soft paraffin, cetostearyl alcohol, polysorbate 40, propylene glycol, glycerol monostearate 40-55, liquid paraffin,medium-chain triglycerides, sorbic acid, colloidal anhydrous silica, sodium hydroxide. Uses: Unguentum M has emollient properties and is recommended for the symptomatic treatment of dermatitis, nappy rash, ichthyosis, eczema, protection of raw and abraded skin areas, pruritus and related skin conditions where dry scaly skin is a problem, and as a pre-bathing emollient for dry/eczematous skin, to alleviate drying effects. It is also used as a diluent for various topical corticosteroid formulations where a lower strength preparation is required and as a general base for extemporaneous dispensing. Dosage and administration: A thin application of cream should be gently massaged into the skin three times daily or at appropriate intervals. When used as a protective cream Unguentum M should be applied sparingly to the affected areas of the skin before, or immediately after, exposure to a potentially harmful factor. Contra-indications, warnings etc. [illegible] be used in patients sensitive [illegible] Undesirable effects: [illegible] 50g and 100g tubes. 200g [illegible] pack. Basic NHS cost: 50g £1.59, [illegible] 29.55, 200ml £6.19. Legal category: [illegible] licence number: PL 00327/0115. Product [illegible] holder: Crookes Healthcare Ltd, Nottingham, [illegible]

Understanding

We know how uncomfortable it can be when eczema, nappy rash, dermatitis, pruritus and other problems make skin dry and scaly.

And we understand that skin in these conditions needs careful handling, so we made Unguentum M ambiphilic.

It has the high lipid content of an ointment combined with the water miscible characteristics of a cream so it glides on and rubs in easily.

Unguentum M. Works like an ointment, feels like a cream.

ROOKES HEALTHCARE
HCSK04-96-D
Date of preparation: September 2004

www.crookes.co.uk/hcpservices

Reid launches GMC review to put patient interest first

by Fiona Salvage

The Government is to review the way the General Medical Council revalidates and ensures doctors are fit to practise.

Health secretary John Reid asserted the GMC's primary role is to protect patients and not to represent doctors. His announcement coincided with the publication of the Government's response to the Shipman Inquiry's fifth report.

The report included measures to revalidate GPs' fitness to practise and modify the GMC's role, structure and functions.

Asked if this had implications for the RPSGB, the Department of Health said it would not because the Society is "a regulator and professional body, not a representative body".

Commenting on the recently announced delay to the section 60 Order, the DoH said: "The section 60 Order (under the *Health Act, 1999*) does not alter the RPSGB's dual role, it updates the powers it has to carry out the regulatory role. The delay in consulting on the Order is not due to any re-thinking of the policy. DoH still aims to get the Order made by the end of 2005."

When asked what this means for the Society, director of fitness to practise and legal affairs Mandie Lavin said the RPSGB has set up a working party to formulate a response to the fifth Shipman report, which contained Dame Janet Smith's recommendations for the GMC.

Eye drop switch welcomed

Both the Royal Pharmaceutical Society and the NPA have welcomed the proposal to reclassify chloramphenicol eye drops from POM to P (*C&D, December 4, 2004, p4*).

But the NPA suggested the product should be indicated for the treatment of "infective conjunctivitis" instead of the proposed "bacterial conjunctivitis".

As it is difficult to differentiate between viral and bacterial infections, current practice is to treat infective conjunctivitis with chloramphenicol eye drops without confirming the cause, the NPA said in response to the MHRA's consultation.

Another suggestion is to lower the proposed age limit from two years to 18 months, because infective conjunctivitis is common in infants. The NPA agreed it was appropriate to refer patients who had recent eye surgery or laser treatment, but suggested the marketing authorisation should have a clear definition of "recent history".

The RPSGB recommended that pharmacists selling the product should receive appropriate training and guidance, in particular to reduce the risk of misdiagnosis (which could also occur in the GP surgery).

The packaging design should allow easy differentiation between chloramphenicol eye and eardrops, with clear labelling that the reclassified product is for use only in the eyes. **AdeM**

Europe calls for 'tighter watch'

European medicines regulators have called for a radical shake-up in the systems for post-marketing drug surveillance.

In an interview with the *Financial Times* to mark the 10th anniversary of the European Medicines Agency (EMEA), director-general Thomas Lönngren criticised the current system, which relies on health professionals and industry to identify safety issues. Although the agency relies on a network of regulators and medical researchers across the EU member states, it lacks an intensive drug monitoring system, he said.

In a year which saw safety scares surrounding drug classes including SSRIs and Cox-2s, EMEA withdrew marketing authorisations for seven human use drugs, two of which were Cox-2s. It also vetoed the licence renewal of another drug. This compares to just one in 2003.

Furthermore, it issued safety alerts for a further three products currently on the market.

Nevertheless, Mr Lönngren believes more should be done to protect patients. He said: "If we had better follow-up in place, we might have discovered problems earlier." **AC**

P&G acquires Gillette

Procter & Gamble has signed a deal to acquire Gillette for $57 billion (£30 billion) – the largest acquisition in P&G's history.

P&G will acquire all of Gillette's business, including manufacturing. The deal, which is subject to regulatory clearance and approval by shareholders, is expected to close this autumn.

P&G's key pharmacy brands include Pampers, Always, Crest, Olay, Nice 'n Easy, Head & Shoulders and Wella. Gillette's portfolio includes Duracell, Braun, Oral-B, and razors and blades.

The companies employ 140,000. Some 6,000 jobs may go initially, although these could return as the company moves into China, Russia, Mexico and Turkey. **AdM**

In brief

Screen ads

In-store digital media network the Pharmacy Channel expects to have screens in 3,000 pharmacies by the end of the summer. The channel airs a mix of health education and advertising messages, which can include those from the host pharmacy. There is no charge for installation. Pharmacy Channel has appointed Hemant Patel, formerly of Kemps Wholesaling, to the post of new pharmacy manager.

Waste not

Bromley and Sutton & Merton PCTs have collected the most unwanted medicine (by weight) of all English and Welsh PCTs/LHBs, latest DoH statistics reveal. In 2003-04, Bromley PCT collected 16,600kg of unwanted medicine, up from 4,300kg the previous year, while at Sutton & Merton 14,200kg was collected between 2003-04, up from 1,100kg.

Lipobay update

Bayer has settled 2,933 cases relating to the recall of Baycol (Lipobay), at a cost of US$1.113 billion. There are 6,359 cases still pending.

Pfizer jobs go

Pfizer is to slash nearly 900 jobs in the UK, following a review of business. Pfizer intends to shed 400 jobs from its site in Sandwich, Kent, although manufacturing will still take place there but its Morpeth, Northumberland site will be sold with the loss of 571 jobs.

Signed, sealed, delivered...

... or will it be? As the April 1 deadline approaches, Adrian Hyde Mant looks at how ready pharmacy software suppliers are likely to be

England and Wales will have a new pharmacy contract in less than eight weeks, and pharmacy IT suppliers are working hard to update their systems to meet the April 1 deadline.

The introduction of electronic transfer of prescriptions is still on target, with ETP pilots starting this month in selected sites and a gradual national rollout expected this summer. But although by April pharmacy systems should be able to cope with essential services, there is no firm requirement for services such as medicines use review to be carried out on a computer.

The Department of Health has promised a £58 million IT allowance for year one of the new contract, to cover the initial set up costs of ETP and access to the NHS Care Records Service. The exact figure per pharmacy has not yet been agreed, as there are still no pharmacy systems that comply with the National Programme for IT. But each pharmacy will receive the same amount, which works out at £5,000 to £6,000 per pharmacy – although it could cost up to £10,000 for a system that integrates the dispensary, the OTC medicines counter and the private counselling area.

The costs of existing pharmacy systems were captured in the cost inquiry, so this has been recognised in the funding for essential services, explains Lindsay McClure, PSNC head of information services. "From April, contractors will be able to claim a one-off allowance to help meet the costs of new IT, for example, new hardware such as barcode scanners and smart code readers (required for ETP), installing connectivity and training staff in the use of new software."

She thinks it unlikely that all pharmacies will claim the IT allowance in year one. Pharmacies will have to declare that they are using an NPfIT compliant pharmacy system, that they are connected to N3 (the new national network being installed at all NHS sites) and that they are willing to transmit electronically to the PPA. Pharmacies continuing to provide an ETP service will receive an ongoing allowance for maintenance and connectivity.

All the system suppliers are working towards NPfIT compliance but some are closer to achieving it than others, she says, adding: "You may want to ask your system supplier when they expect to undergo compliance testing."

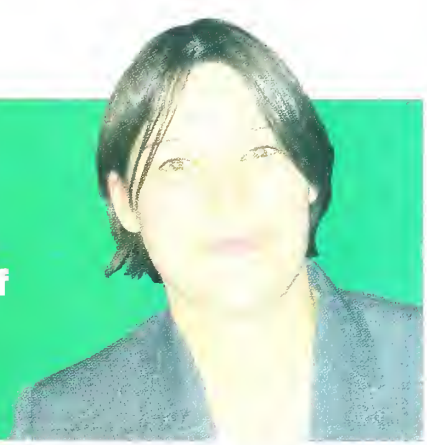
The NPfIT will test the functionality needed for ETP but the DoH has not as yet imposed requirements on support for other aspects of the contract. Many suppliers are developing innovations such as appointment booking software to manage medicines use reviews, together with ways of identifying patients in target groups.

But initially, contractors will be able to carry out new services without the relevant computer support, for example repeat dispensing will use a paper-based system until ETP is introduced.

"Your pharmacy system will play an increasingly important role in the success of your business," says Ms McClure. "You will need a system that allows you to dispense efficiently using ETP and supports you in delivering the new services. Take time now to learn what options are available to you."

"From April, contractors will be able to claim a one-off allowance"

Lindsay McClure



"We have been delivering many of the new services in Ireland for up to eight years"

Nick Strong

System suppliers are best placed to advise on an individual pharmacy's requirements, she adds. "They will be able to tell you if your computer system needs to be replaced, what additional hardware you need for ETP and the functionality they are developing to support new services."

Nigel Cox, NPA pharmacy systems development executive, says the emphasis at present is on understanding at local level what services the primary care trusts will want pharmacies to provide. The NPA has developed pharmaceutical needs assessment toolkits with the National Primary and Care Trust Development Programme.

"From this I would envisage more formal requirements to be developed for pharmacy system suppliers and for contractors to decide their level of investment in, say, consultation areas."

Over time, PCTs will commission advanced/enhanced services according to local, national and political priorities. Pharmacy system suppliers have to implement the dictionary of medicines and devices (dm+d) for ETP and prepare to use SNOMED clinical terminology. Another key driver will be clinical governance and the focus on the patient. The systems will develop to meet the needs of the new contract, ETP and changes to the business environment, but Mr Cox says: "I am pretty sure it will not be overnight.

"Another certainty is that funding will always be an issue and, now that PCTs can decide what they want to spend their money on, it might be even more confusing for us all."

IT supplier Positive Solutions expects to be ready for ETP by April. The NPfIT has given the Analyst IPS system the go ahead to enter the accreditation process. This will allow users to be among the first wave of pharmacies capable of linking to the full ETP messaging system.

Commercial manager Martin Jones says it seems likely that contractors will be able to claim their share of the IT allowance as soon as they have an accredited PMR system installed, regardless of whether ETP is running in their PCT.

Positive Solutions is so confident of achieving ETP accreditation that pharmacies installing a compliant system will not have to pay for it in full until they have received their share of the allowance. The company is prepared to defer payment up to the value of this subsidy until the NHS has reimbursed the contractor.

But Mr Jones warns: "Single-user systems are no longer adequate for the demands of a modern pharmacy." In future the company's standard package will consist of multi-user networks capable of carrying out several tasks at once. "This equipment doesn't come cheap and I would expect pharmacists to be planning on investing several thousand

Continued on page 10

pounds per site in order to reach the required standard enabling them to stay ahead of their local competition."

The company regards the ETP pilots being launched this month to be of little significance as they are likely to test only some of the functions to be carried out between pharmacies and the central NHS computer. Mr Jones says: "These pilot sites will be limited in scope and lacking in any obvious business benefit. NPfIT's larger timetable for full accreditation during 2005 is the one to look out for."

Positive Solutions will provide training for each Analyst IPS system and existing customers will be able to upgrade easily.

Enigma Health will offer two ETP-enabled systems – Mediphase and Nexphase, although the ETP facility will not start in April, as the NPfIT pilots will still be under way. Nexphase will include services such as medication use reviews from April, whereas these may take longer to introduce to Mediphase.

Pharmacies will be able to upgrade their existing systems, but some might need to make additional investments in IT before being able to use the new facilities. Farid Poonja, head of external relations, says it is impossible to give an idea of costs until there is N3 connectivity. The company will offer training and support.

Systems Solutions plans to deliver a fully compliant NPfIT pharmacy contract system by the end of 2005. This will include all essential, advanced and enhanced services, as well as ETP.

Its QicScript system already delivers on many of the new contract requirements. Contract specific features in place by April 1 will be:

- dispensing – complete PMR and full drug usage review
- public health review, with advice printed on drug usage review labels
- repeat dispensing
- self-care, including domiciliary dosage service
- clinical governance, by monitoring owings and adverse reactions and maintaining an audit trail of all activity.

A head office module enables pharmacy superintendents to access all data centrally. Introduction will be in two stages:

Stage one will include ETP, minor ailments handling and interventions recording.

Stage two will include medicines use reviews and

"Single-user systems are no longer adequate for the demands of a modern pharmacy"

Martin Jones

enhanced concordance features.

Managing director Nick Strong says: "We have been delivering many of the new services in Ireland for up to eight years and it is a relatively simple matter of integrating these features into our UK system."

Existing customers will be able to upgrade. The company has an agreement with Vista Retail Support to offer QicScript software, hardware and ongoing hardware support to pharmacies throughout the UK. The software already has an in-built training facility and the company will also be releasing computer-based training material in stage one.

AAH Pharmaceuticals was unable to disclose what facilities the Link pharmacy system will offer by April, apart from assuring users that it will simple.

"If you're a Link user today, any new functionality can be used immediately," says Geoff Mackay, customer technology controller. "For example, existing users can be up and running with the new ETP interface within minutes."

For new users, training and help functions are built in.

He believes most ETP and new contract-enabled systems will cost close to the amount of money on offer in the contract.

"Why? Because systems have for too long been undervalued by pharmacy and that dynamic will have to change." But the investment will carry high returns in terms of future growth and profits, so it is crucial that pharmacists choose a provider with a solid pedigree and stable future, he says.

PAGB PERSPECTIVE

A fairer incentive

Is a year's market exclusivity a trigger for more POM to P, asks PAGB executive director Sheila Kelly

Why would companies invest in switching old ingredients if competitors can join them in the market by piggy backing on their work without having to do any new research or work of their own?

This major deterrent to switching ingredients which are out of patent was removed when a new regulation came into force in the UK on January 1. It gives a year's data protection to a company which submits an application for switch based on significant clinical and pre-clinical data.

As governments want to widen access to medicines, the need to provide a regulatory incentive has gained acceptance. In the USA and Japan, POM to P switches get three years' exclusivity; the EU has been more parsimonious but it's a step in the right direction.

Until now, when ingredients are out of patent there is no incentive for manufacturers to invest in the work needed to review the safety of the molecule, carry out clinical studies if necessary and then undertake training for pharmacists and their staff. The investment in marketing and advertising often ends up benefiting an own-label or generic brand.

This has been a long-standing problem for industry. In the 1980s, the first big switch, Nurofen, based on new clinical trials and years of work, was joined on the market immediately by half a dozen generic companies; the hydrocortisone switch saw 14 product launches on the same day. Is it any wonder that more recent switches have been brought through within the patent period and older molecules have languished?

So what's the benefit to consumers and pharmacists now? The period of exclusivity doesn't just apply to the company which originally developed the molecule; it is given for the data and work which is done to support the switch. That means that all sorts of companies will be looking at older molecules and wondering if there is an OTC market for them.

A bit of guidance to the potential was published a while ago when research with a sample of pharmacists showed that their top 10 list of switch areas were products for migraine, psoriasis, lower urinary tract antibiotics, oral contraceptives, obesity drugs, osteoporosis, asthma, cholesterol lowering and diabetes. In many cases the pharmacist knew what the doctor would prescribe and it was frustrating to offer advice to a customer then have to finish the discussion by sending him or her to the doctor to get the prescription. With the caveat that there needs to be a lot of training and support from manufacturers, pharmacists felt that in most of these areas they would feel able to recommend an OTC product if it were available.

Many of the drugs available for these ailments are out of patent and this new regulation will encourage manufacturers to take a fresh look at the sector. A year sounds a long time but it takes that to do a good job of pharmacy training and patient education, not to mention establishing the brand and managing the distribution before the product is launched. It will be a while before products come through the pipeline under the new regulations. When it is in place, pharmacists will have to adapt to the situation that products which have the same active ingredient and dosage may have different legal status but the regulation is welcomed by industry as a long overdue incentive.

The new Community Pharmacy Contract

Supporting you all the way

With the new Community Pharmacy Contract just around the corner, UniChem have sponsored and supported the Pharmacy Vision CD-Rom – an essential tool you shouldn't be without.

- It explains all the key points of the new Community Pharmacy Contract
- Viewing the CD-Rom counts towards four hours Continuing Education accredited by CPP
- It will help you make the most of the opportunities that the new Community Pharmacy Contract will bring

You'll find a copy of this CD-Rom in this publication, or you can view it online at www.theclinicalchannel.tv

We have the solutions

Service | Availability | Price | Range | **your portfolio** – Solutions

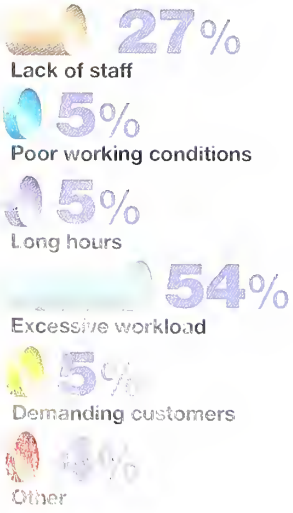
UniChem

Our question to pharmacists this week was:
With the RPSGB looking at the pressures faced by community pharmacists, what is top of your stress list?

"CPD: the sheer bureaucracy of it. Actually doing it isn't a problem, I've been doing it since I qualified"
Pamela Brooks, Yarm

"The new contract and everything associated with it. It's fitting everything in with what we do now"
Anonymous, Bangor

Our online poll at *www.dotpharmacy.com* said...



Comment from the Editor

Events such as the Bristol Infirmary, Alder Hey Hospital and Harold Shipman cases are having a huge impact on the principles upon which NHS care is, and will be, provided. Risk management, of which patient safety is a major element, is top of the agenda for both health professionals and politicians.

The MHRA's decision on Monday to withdraw co-proxamol should therefore come as no surprise. It found that co-proxamol is associated with 300 to 400 intentional and accidental fatal overdoses each year – an unacceptable statistic – and has instigated a phased withdrawal over the next 12 months.

Yet again this situation highlights the point that there is a risk associated with taking any medicine, be it a tolerable side effect or something more serious. It is health professionals who bear the responsibility of ensuring patients understand these risks which come with their treatment options.

Alongside this, a Commons health select committee is currently looking at the influence of the pharmaceutical industry on a range of areas including the NHS and research. The recent high profile drug withdrawals will have exerted an influence on its deliberations that the industry and officials could not have anticipated when the inquiry began.

The MHRA is good at what it does but it is not beyond criticism. Recent events have put it in the firing line, but the select committee's report should ensure greater transparency around clinical information, something both patients and the health professionals should welcome.

There is a risk associated with taking any medicine, be it a tolerable side effect or something more serious

Yourviews E-mail your views to chemdrug @ cmpinformation.com

David Coles looks ahead to new challenges for the supply industry

Help from the wholesaler

This is a key time for the full-line wholesale industry to be positioning itself as integral to our pharmacy customers' preparations for the new community pharmacy contract.

We should by now have turned our attention to supporting our customers in meeting the requirements of essential services. Many pharmacists do not have the time to study the requirements of the 'essential level', so it is the wholesaler's responsibility to assist them. We must consider how we can provide pharmacists with the relevant advice and tools for the easy implementation of the services, which will ensure that they are able to meet the new criteria as effectively as possible.

Everything from loans and insurance to merchandising support and own-brand product ranges – anything that makes our customers' lives easier and gives them a competitive edge.

The new contract is a huge opportunity for community pharmacists and its introduction brings with it new challenges and opportunities for the wholesaler too. We have always played an integral, yet often overlooked part in the medicines supply chain, and now is the time to raise our profile as an integral part of the service supply chain too. But we must not assume that we know best. We have to listen to pharmacists if we want to stay ahead of the game. With their input we can identify the areas where they require support and can act upon this in an informed manner – they are the experts after all.

This is no time for complacency; wholesalers should be banging on the pharmacist's door and asking "What can we do for you?" I believe that this two-way dialogue will become the key to any wholesaler's success in a rapidly evolving marketplace.

David Coles is managing director of UniChem and chairman of the British Association of Pharmaceutical Wholesalers

TOPICAL REFLECTIONS

Medicines use reviews – who needs them?

Pharmacists' medicines use reviews have been shown to increase hospital visits (*C&D, Jan 29, p26*). Oh dear, there doesn't seem much point doing them in that case then. Or does there?

The study concluded that because pharmacist advice meant patients were more likely to take their medicines they were more likely to suffer adverse events and end up in hospital.

This raises a worrying question – if these people visit hospital less when they don't take their medication, should they be taking it in the first place? Of course many side effects will be immediately obvious whereas the medication's beneficial effects will often be more longer term. But this isn't always the case. More hospital visits in the study made this a costly exercise, but improving compliance has never been simply about saving money. As with other measures that lead to increased costs, such as some NSFs and NICE guidance, compliance is part of effective healthcare.

Assuming that most drugs do provide an overall benefit, the good news is that pharmacist advice improves compliance and increases understanding of health problems. Most of us would like to get involved in medicines use reviews so let's hope our paymasters continue to think compliance is desirable.

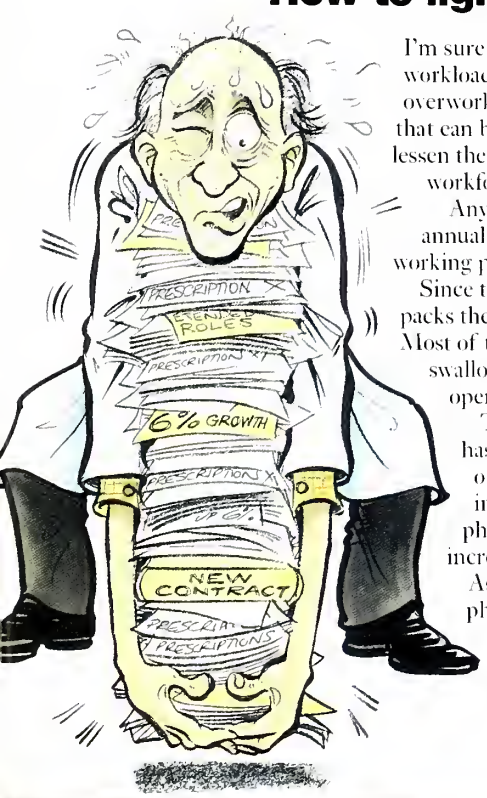
When the Amplichips are down

Roche's Amplichip heralds a whole new age for prescribing (*C&D, Jan 29, p10*). It will take much of the guesswork, or artistry if you prefer, from selecting the best drug and its optimum dose in each case and allow prescribers to prescribe on a truly individual basis.

This is but the tip of the iceberg for the improvements in medicine that understanding genetics will allow. Eventually many diseases will be preventable by altering patients' DNA. Whether or not parents will be allowed to choose their baby's eye colour remains to be seen but they will certainly know that their child will not develop a range of health problems.

This sort of progress is slow enough for me not to worry about but I wonder what will be left for later generations of pharmacists to do. Many diseases will simply disappear in this country and the remaining prescribing could be done by computer using genetic information. Future would-be pharmacists may be better considering genetics or IT as alternative healthcare careers.

How to lighten pharmacists' workload



I'm sure that the RPSGB's investigation into pharmacists' workload (*C&D, Jan 29, p4*), will find that we are intolerably overworked, but the solution is not so obvious. There is little that can be done quickly to either stem the increasing script volume, lessen the demands of the new contract, or increase the size of the workforce.

Any other profession whose workload grew by 6 per cent annually would be making either significant efficiencies in its working practice or increasing its workforce. We are doing neither.

Since the introduction of PMR systems and widespread patient packs there have been no real efficiencies made to our work practice. Most of the graduates from the new schools of pharmacy will be swallowed up by the requirements of extended roles, longer opening hours and more part-time work.

The problem has been that growth in dispensing volume has funded our annual pay rise. So despite being on the verge of a nervous breakdown we are unlikely to complain about increasing script numbers. Employing additional pharmacists (if there were any around) would make any pay increase disappear instantly.

As the Government is unlikely to pay for additional pharmacist cover, the only way to preserve pharmacists' sanity is to remove the final check requirement. There is a limit to the number of prescriptions I can safely check in a day and I surpassed that number some time ago.

Keeping up to date

With details vague and communication intermittent, it is difficult to say with much certainty if CPD will be mandatory in Northern Ireland from June.

A CPD pilot to establish which format it will take and what will be required of pharmacists is running and I now regret that I ignored the offer to take part. A year ago I was clear about CPD and what it was; now I'm not sure. Fundamental questions remain that I haven't had answered such as "What is the true purpose of CPD?"

Also, I would like to know if CPD will protect the public from poor performance. Will it ensure that all pharmacists keep up to date and are competent? And what is competence anyway? I'm not sure that CPD will properly address any of these questions.

That said, I am taking a positive and proactive approach to CPD and recording what personal development I undertake. I am using a diary and will keep the process as simple as possible.

A year ago I was clear about CPD and what it was

What is clear is that medicines management skills will be a key element of the work that I will get paid for, yet it requires a set of skills I do not currently possess. I therefore have identified this area for my CPD and have picked out a number of courses from the current NICPPET brochure, which offers a relevant menu of appropriate courses.

So my CPD begins in earnest yet I still require more detail on what I need to do and how to do it. Will what I record be sufficient to satisfy that ever-burgeoning tribe of bureaucrats who control and regulate even the remotest corners of my profession?

Written by a Northern Ireland community pharmacist

Time to overhaul the Statutory Committee?

David Reissner of Charles Russell solicitors certainly thinks so. He says it's not representative of the membership and is stuck in a time warp

The *Health Act 1999* gave the Government power to create new disciplinary procedures for the pharmacy profession, and a consultation exercise is promised for later this year, followed by an Order under section 60 of that Act.

This will be welcome because pharmacy is in serious need of modern disciplinary processes. Since 1933, professional discipline has been exercised mainly through the Statutory Committee of the Royal Pharmaceutical Society and little has changed in 72 years.

The Statutory Committee has six members including the chairman. The chairman is appointed by the anonymous Privy Council, and must be legally qualified. The other members are appointed by the Society's Council. There is a legal requirement to have a member resident in Scotland, but no requirement to have any Welsh members or black, Asian or female members. There is no requirement to have recent experience of pharmacy practice in any sphere. Members of the Committee have a five-year term of office and can be re-appointed.

Currently, the Committee has one lay member. All the other members, apart from the chairman, are pharmacists.

This composition of the Statutory Committee gives rise to several serious problems:

- There is no alternative chairman or vice-chairman, so that if the chairman is indisposed, the Statutory Committee cannot meet.
- Almost all complaints of misconduct are made to the Statutory Committee by the Society's Council – which has appointed all bar one of the Committee's members. This fails to meet the requirement in the *Human Rights Act* for an independent tribunal.
- If the High Court upholds an appeal against a Statutory Committee decision, judges cannot send the case back to be re-heard by a differently constituted Committee.
- The Committee is not representative either of the membership of the profession, or of the people who appear before it, in terms of ethnic background, gender, or sphere of practice.

The small size of the Committee and the eligibility of members for re-appointment can mean it is difficult for the Committee to adapt in a rapidly changing professional world. There has been very little change in the membership of the Committee over recent years. When a new member is appointed, his or her views will inevitably be influenced by the views of existing members as to what is misconduct and how serious it is.

It is not only the composition of the Statutory Committee that is out of date. Its rules of procedure are also stuck in a time warp. Once a decision has been made to hold an inquiry, up to a year may pass before a hearing takes place. The current rules require any pharmacist accused of misconduct to receive a formal 'Notice of Inquiry' at least 28 days before a hearing.

This notice is an important document, specifying exactly what allegations the pharmacist has to meet. Since the Statutory Committee has the power to remove a pharmacist's name from the Register, 28 days is hardly a sufficient period to allow someone to prepare the defence of their reputation, livelihood and professional standing.

The Statutory Committee has only limited power to deal with pharmacists found guilty of misconduct. It can admonish, reprimand or strike off, but only if it considers the misconduct is so serious as to render the pharmacist unfit to be on the Register. This means that a simple dispensing error can be stigmatised as rendering a pharmacist unfit, even if the result is only a reprimand. There is no power to suspend a pharmacist from practice.

Currently, there are no formal arrangements for the Society to deal with pharmacists suffering from alcoholism, drug dependency or other illnesses. Such cases are often treated as misconduct and referred to the Statutory Committee, with striking off, rather than treatment, as the result.

The Society has offered few clues as to what an Order under section 60 of the *Health Act 1999* will say. But, following the reports of Dame Janet Smith in the Shipman Inquiry, a greater lay element on the Statutory Committee seems inevitable.

One idea would be to draw a tribunal for each case from a panel of potential members, say 25, with a chairman and two vice-chairmen. The chairman and vice-chairmen should be legally qualified.

It is not only the composition of the Statutory Committee that is out of date. Its rules of procedure are also stuck in a time warp

An appointments board, the members of which would be nominated by the Society's Council but would not include any member of Council, would select the panel. Potential panel members should apply in the same way that judges now apply for appointment, in response to public advertisement.

Appointments should be made through open competition and should take account of the make-up of the profession in terms of practice, ethnic background and gender. Members of the Society's Council would not be eligible. Members would have a renewable three-year term of office.

A tribunal of between three and six members drawn from the panel would hear each case. It would include the chairman or a vice-chairman (who would preside), and there should be a balance between pharmacists and lay members. In a case involving a hospital pharmacist, the tribunal should include at least one member with relevant experience, and so on.

Occasionally, pharmacists awaiting an inquiry are invited to give an undertaking not to practice pending a final hearing of their case. However, this can only operate on a voluntary basis.

Under new rules, the Society or the Statutory Committee will probably be given the power to suspend pharmacists from practice pending the outcome of an inquiry, if this is considered necessary for the protection of the public. The archaic and unused power to admonish pharmacists will probably be abolished.

The pharmacy profession has waited a long time for a modern disciplinary process. When it eventually comes into operation, we can only hope it will have been worth the wait.

My pharmacist said "Before you quit smoking, make sure you've got a plan."

Designed to give your customers personalised support throughout their quitting journey, the Click2Quit Stop Smoking Plan is clinically proven to help increase their chance of success.[1]

By recommending the Click2Quit Stop Smoking Plan, you'll be giving your customers information and advice before, during and after their quit attempt to help them stay strong while they try to give up smoking for good.

Customers can visit **Click2Quit.com** *for their personal quit plan.*

NiQuitin CQ®
Nicotine

Quit with NiQuitin

NiQuitin CQ 21, 14, 7mg Transdermal Patches, NiQuitin CQ Clear 21, 14, 7mg (nicotine) opaque or transparent transdermal patches 21 mg, 14 mg, 7 mg nicotine (Steps 1, 2, 3) for relief of nicotine withdrawal symptoms during smoking cessation. Dosage. Stop smoking completely. *>10 cigarettes/day;* Step 1 for 6 weeks, then Step 2 for 2 weeks, then Step 3 for 2 weeks. *<10 cigarettes/day;* Step 2 for 6 weeks then Step 3 for 2 weeks. Complete full course. Max 10 consecutive weeks. Apply to fresh site (clean, dry skin) once daily. **Contraindications:** non/occasional smokers, children under 12. Recent MI/ stroke, severe arrhythmia, unstable/worsening/ resting angina Hypersensitivity. **Precautions:** adolescents 12-17 years, cardiovascular disease including uncontrolled hypertension, severe renal/hepatic impairment, peptic ulcer, hyperthyroidism, insulin-dependent diabetes, phaeochromocytoma, dermatitis Concomitant medication may need dose adjustment. **Side effects:** Local rash, itching, burning, tingling, numbness, swelling, pain, urticaria, heaviness. Depression, irritability, anxiety, nervousness, restlessness, mood lability, drowsiness, impaired concentration, insomnia, sleep disturbance. Allergic reactions, abnormal dreams, nausea, vomiting, dry mouth, GI disturbance, headache, dizziness, palpitations, tachycardia, tremor, dyspnoea, pharyngitis, cough, arthralgia, myalgia, sweating, chest pain, fatigue, malaise, flu-like symptoms **Pregnancy/lactation:** try without nicotine replacement therapy Medical assessment of risk/benefit if necessary **GSL PL** 00079/0347, 0346, 0345, 0356, 0355 & 0354 **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS U.K **Pack size and RSP:** All strengths 7 patches £17.49, Step 1 only 14 patches £32.95 **Date of revision:** March 2004

Reference: 1. Strecher V *et al.* Poster presented at the 12th World Conference on Tobacco or Health, Helsinki, 3-8 August, 2003

Pharmacy Update 2005

Pharmacy Update – continuing education for pharmacists and pharmacy technicians

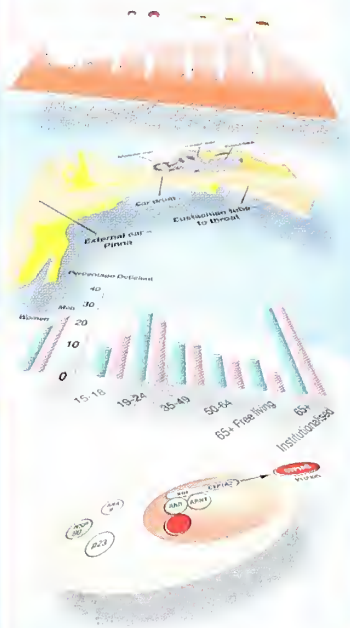
Put Pharmacy Update in your CPD portfolio for 2005

Register before January 31, 2005 and....

- Save **£5** on the annual registration fee of £30
- Get **automatic entry** to Knockout 2005 with **£3,000** to be won

Update knockout is back in 2005 with **£3,000** in prize money. Sign up for one of community pharmacy's most popular continuing education courses before January 31 and you could profit from your learning with a prize of **£1,000** or **£2,000.**

- Complete the Update question papers each month
- Get one question wrong and you are knocked out
- Keep a clean sheet up to the eliminator stage and you will be registered **free of charge** for Update 2006
- Get top marks in the eliminator papers in 2005 and you could win either first prize of **£2,000** or second prize of **£1,000**



GENUS PHARMACEUTICALS

Update**Knockout** is supported by Genus Pharmaceuticals.

- Pick up the phone to pay by credit or debit card. Call Mary Prebble on **01732 377269**

Join the GENUS challenge!

Genus Pharmaceuticals, sponsor of Pharmacy Update, has set pharmacists a CPD 'charity challenge' for 2005.

- If 1,000 pharmacists sign up to Update in 2005 Genus will donate **£2,000**
- If 1,500 pharmacists sign up to Update in 2005 Genus will donate **£5,000**
- If 2,000 pharmacists sign up to Update in 2005 Genus will donate **£10,000**

The donation will go to the charity listed below which receives the most votes from pharmacists or pharmacy technicians who register for Pharmacy Update 2005. Make your vote count when you register:

- TB Alert (*www.tbalert.org*)
- RPSGB Benevolent Fund (*www.rpsgb.org.uk*)
- Great Ormond St Hospital Children's Charity (*www.gosh.org*)
- Shelter (*www.shelter.org.uk*)

Pharmacy Update 2005 – the benefits

- Over 30 hours of CPP accredited learning
- Access to *C&D's* telephone marking service for registering your answers and checking your results
- If you miss a module or question paper, visit *www.dotpharmacy.com* – it will be there
- Northern Ireland pharmacists will have their registration fee paid by NICPPET

Return this completed coupon and your cheque (payable to CMP Information) to Mary Prebble, Pharmacy Projects, CMP Information Ltd, Sovereign House, Sovereign Way, Tonbridge, Kent TN9 1RW.

❑ Please register me for Pharmacy Update in 2005. I am taking advantage of the New Year deal to register before January 31, 2005. I enclose a cheque payable to CMP Information for £25

❑ Tick this box if you are registering for Pharmacy Update before January 31, 2005, but DO NOT want to be automatically entered for Update Knockout 2005

❑ I am a pharmacist registered and practising in Northern Ireland and wish to register under the NICPPET scheme (do not send a cheque). My PSNI registration number is:_____

Name_____

Address_____

_____

Postcode_____

Signature Date

Daytime phone number_____

E-mail address (if available)_____

The Genus Challenge – Vote for the charity of your choice. Which charity would you like to support? (see above):

❑ TB Alert ❑ Shelter ❑ RPSGB Benevolent Fund

❑ Great Ormond St Hospital Children's Charity

CPD

This article can help in the following areas of competence as set out in the RPSGB's CPD manual: **G3, G6, G7, G15.**

In this final article on cytochromes P450, *Professor Danny Burke* explains how knowledge of these enzymes will have an increasing influence on treatment choice

Tailoring drugs

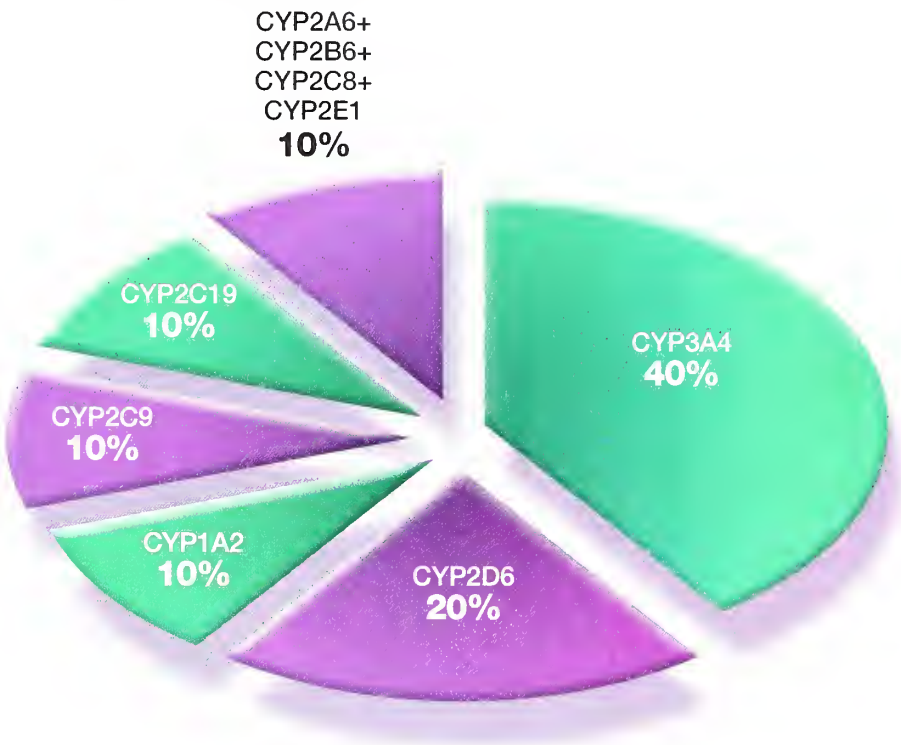
This article is the third of three designed as a simple introduction or refresher on why CYP enzymes feature so frequently in warnings about drug interactions and adverse drug effects.

The first article described the salient features of CYPs, while the second considered their inhibition or induction by drugs (*C&D, October 2, p23* and *November 13, 2004, p29*). This final article examines CYP genetic polymorphism, inhibition and induction of CYPs by natural products, and some CYP-dependent diseases. Only the main human drug-metabolising CYPs are considered.

The actions and excretion of 90 per cent of drugs in humans are affected by their metabolism by a collection of nine CYP enzymes (*Figure 1*). Drug interactions and adverse effects can occur when the normal metabolism of drugs is altered, either as a result of the inhibition or induction of CYPs by other drugs, or as a result of innate genetic deficiencies in CYPs (*Table 1*).

For example, nortryptiline is metabolised by CYP2D6. In patients who are genetically deficient in CYP2D6 the blood level of nortryptiline can be so abnormally high as to necessitate a six-fold reduction in dose.

Figure 1: Relative contribution that each CYP enzyme makes to the metabolism of all drugs in use



Genetic polymorphism

The activities of all CYPs differ between individuals for various reasons, but there is a particular type of variability that is genetically based and results in an extreme lack of CYP2A6, 2C9, 2C19 or 2D6 activity in some people. This so-called 'genetic polymorphism' occurs in people who have abnormal versions of the relevant CYP genes.

The result is an extremely slow rate of metabolism of those drugs that are normally metabolised by the deficient CYP. Such people are said to be 'poor metabolisers' (or PMs) for the deficient CYP and of the drugs that are normally metabolised by it, while the normal population are 'extensive metabolisers' (or EMs) for the same CYP and drugs (*Figure 2*).

Ethnic variation

The incidence of the PMs varies between races and between CYPs, ranging from 5 to 30 per cent of most populations. For example, about 3 per cent of European or North American Caucasians and 20 per cent of Japanese are PMs for CYP2C19, while around 8 per cent of Caucasians and 2 per cent of black Americans are PMs for CYP2D6. A third trait, the 'ultra rapid metabolisers' (or UMs), has also been recognised in some people, including 5 per cent of Caucasians and over 25 per cent of Ethiopians, who display an abnormally high level of CYP2D6 activity.

Clinical significance

The drugs that are most likely to have unexpectedly high blood levels and consequently enhanced pharmacological or even toxic effects in certain patients are those drugs that are specifically metabolised by polymorphic CYPs. Whereas the normal dose of nortryptiline is 75 to 100mg, 10 to 20mg often suffices in CYP2D6 PMs because the drug's blood level is abnormally high as a result of its inadequate metabolism. On the other hand 300 to 500mg can be needed in CYP2D6 UMs in whom nortryptyline's blood level is abnormally low because of its excessive metabolism.

Perhexiline caused neuropathy in CYP2D6 PMs and was withdrawn. In patients who are PM for CYP2C9, warfarin metabolism is decreased to the extent that its dose may need reducing to avoid bleeding. CYP2C19 metabolises omeprazole and patients who are PM for CYP2C19 show higher blood levels of the drug and enhanced suppression of gastric acid compared with EMs, although there is no better control of gastro-oesophageal reflux. It is contentious, however, whether eradication of *H pylori* by omeprazole plus antibiotics is similarly enhanced in

Continued on page 18

Table 1: Common CYP–drug interactions

CYPs that metabolise ●, are inhibited by ●, or are induced by ●, a selection of medicines and natural products. Metabolism by CYP2C9, CYP2C19 or CYP2D6 is subject to genetic polymorphism and will be exceptionally slow in poor metabolisers.

DRUG	CYP1A2	CYP2C9	CYP2C19	CYP2D6	CYP3A4
		subject to genetic polymorphism			
Amiodarone		● ●		●	● ●
Amitriptyline	●	●	●	●	●
Atorvastatin					●
Caffeine	●				●
Cannabis		●			●
Captopril				●	
Carbamazepine		●			● ●
Celecoxib		●			
Ciclosporin					●
Cimetidine	●			●	●
Ciprofloxacin	● ●				
Citalopram			●		●
Clopidogrel	●				●
Codeine				●	●
Dextromethorphan				●	●
Diazepam		●	●		●
Diclofenac		●			●
Diltiazem					● ●
Erythromycin					● ●
Ethinylestradiol					●
Felodipine					●
Fluconazole		●			●
Fluoxetine		●	●	● ●	
Grapefruit juice					●
Ibuprofen		●			
Ketoconazole					● ●
Lansoprazole			●		●
Loratadine				●	●
Losartan		●			●
Methadone				●	●
Naproxen	●	●			
Nifedipine					●
Ofloxacin	●				
Omeprazole	●		● ●		●
Paracetamol*					
Paroxetine				● ●	
Phenobarbital		●			●
Phenytoin	●	●			●
Prednisolone					●
Progesterone			●		●
Propranolol	●		●	●	
Rifampicin		●	●		● ●
Ritonavir				● ●	● ●
Sildenafil		●			●
Simvastatin					●
Smoking /nicotine**	●				
St John's wort					●
Tamoxifen		●		●	●
Theophylline	●				●
Valproate		●	●		●
Verapamil	●	●			● ●
Warfarin***	●	●	●		●

*Paracetamol is normally detoxified through non-CYP pathways, but overdoses or chronic alcoholism can result in its metabolism by CYP2E1 and consequent liver damage. **The pharmacologically more potent S-enantiomer of warfarin is metabolised mainly by CYP2C9, whereas the weaker R-enantiomer is metabolised by CYPs 1A2, 2C19 and 3A4. ***CYP1A2 is induced by the polycyclic aromatic hydrocarbons in cigarette smoke, while nicotine is metabolised by CYP2A6, which is subject to genetic polymorphism

The table lists only the main CYP relationships for each drug or therapeutic class. Many of the drugs exhibit or may have CYPs other than those shown, but do so relatively weakly (which can still have significant clinical consequences). Additionally, when any two drugs metabolised by the same CYP are co-ingested, there is a high probability that one drug will inhibit the metabolism of the other. The article has been compiled from reviews in the bibliography to Part 2 (C&D, November 13, 2004). Details/information about CYP interactions in a clinical context is best found in reviews on a narrow class/specific range of drugs or therapeutic area, for example, "Clinical implications of pharmacokinetic interactions with cardiac" by W R Garnett Pharmacotherapy, 2001, vol. 21, p1223-1232 (also available from medscape.com/viewarticle/409704_print).

CYP2C19 PMs.

Prodrugs are also likely to be less effective in PMs. For example, PMs for CYP2D6 may be less responsive to codeine because of lower conversion to its analgesic metabolite, morphine.

The US Food and Drug Administration has recently cleared for marketing the first CYP polymorphism clinical testing kit, the AmpliChip Cytochrome P450 Genotyping Test from Roche Molecular Systems, which will detect from a blood sample whether a person is EM, PM or UM for CYP2D6.

The reason given for the approval is to help prescribers determine the optimum drug and dose for the individual patient, particularly of antidepressants, antipsychotics, beta-blockers and some chemotherapy agents.

Similar tests for other polymorphic CYPs are expected, raising the eternal problem of whether the extra cost will be deemed justified by a less chancy clinical outcome. And as patients are ever better informed about their medication, individuals might welcome being able to find out their own CYP polymorphism status by visiting their local pharmacy for a simple blood test.

Alleles

A CYP gene can be either normal or mutant. CYP polymorphisms are generally caused by mutations affecting between just one and five of the approximately 1,500 DNA bases (that is, letters of the genetic code) that define each CYP in its gene. For CYP2D6, over 40 alternative forms of the gene (or alleles) have been discovered, although just three of these alleles account for over 90 per cent of all CYP2D6 polymorphisms.

Each variant form of CYP protein produced by a specific allele is designated by a suffix, for example, protein CYP2D6.4 is produced by allele CYP2D6*4. The normal CYP2D6 allele and one of the mutant alleles each produce a fully active enzyme, whereas each of the other mutant alleles gives rise to either a less active or completely inactive form of the protein.

Everyone has two copies of each CYP gene, one inherited from their father and one from their mother. CYP2D6 EMs have at least one 'full activity' allele, whereas PMs have two 'zero activity' alleles. EMs with one 'full activity' allele and one 'zero activity' allele have a low, intermediate CYP2D6 metabolic activity (corresponding to the five bars to the right of 0.1 on the horizontal axis in *Figure 2*). The UM phenotype is due to an overabundance of the 'full activity' mutant allele, CYP2D6*2. Similar properties explain the other CYP polymorphisms. Some alleles are specific to particular ethnic groups.

If CYP2D6 PMs have no active CYP2D6 at all, why is it that in these individuals drugs that are metabolised by CYP2D6 are usually metabolised at a very low rate and not at zero rate? The answer is that in such cases other CYPs take over the drug metabolism, but very inefficiently. Moreover, drugs are cleared from the body not just by metabolism, but also by excretion of the original ('parent') drug itself, although for most drugs this latter process accounts for only a minor proportion of the dose. In PMs and UMs clearance by excretion of the parent drug will generally continue as normal.

Factors affecting CYPs

Grapefruit juice

Grapefruit juice can raise the plasma levels of many drugs that are given orally and which have the twin attributes of low bioavailability and extensive metabolism by CYP3A4.

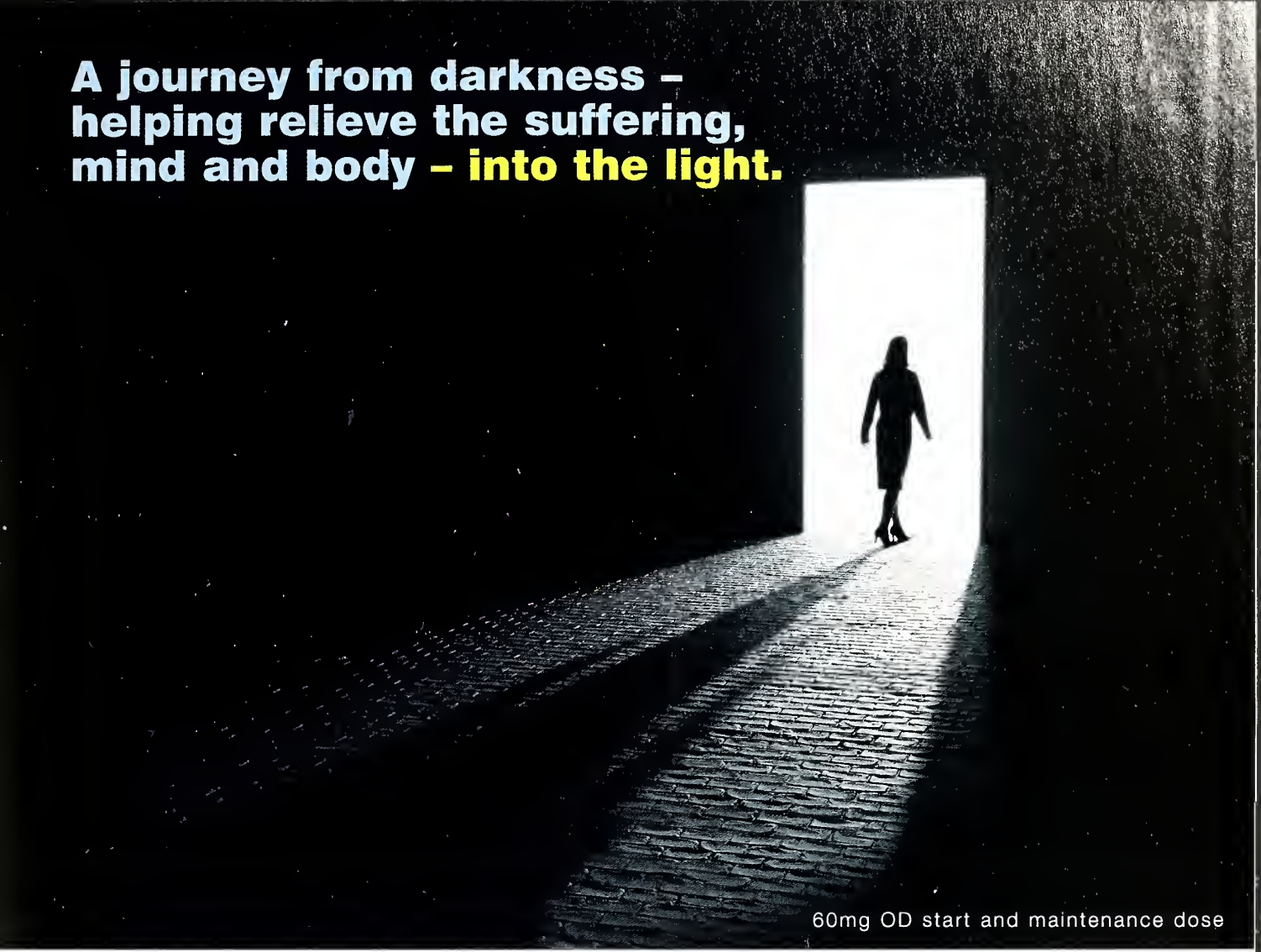
Examples include amiodarone, felodipine, lovastatin, midazolam and saquinavir. The low bioavailability results from extensive 'first pass metabolism' of the drugs during their absorption from the small intestine. This is done by CYP3A4 in the enterocyte cells lining the small intestine. As a result only a small proportion of the oral dose remains to enter the bloodstream.

Chemicals in grapefruit juice, such as furanocoumarins, inhibit the enterocyte CYP3A4, thereby decreasing the drugs' first pass metabolism and increasing their bioavailability, their plasma concentration and their pharmacological effect.

Individuals vary in their sensitivity to grapefruit juice inhibition, but one 250ml glass of normal 'supermarket strength' grapefruit juice can cause inhibition within about an hour and, for example, elevate the plasma level of midazolam by 50 per cent. Because the grapefruit

Continued on page 20 ▶

A journey from darkness – helping relieve the suffering, mind and body – into the light.



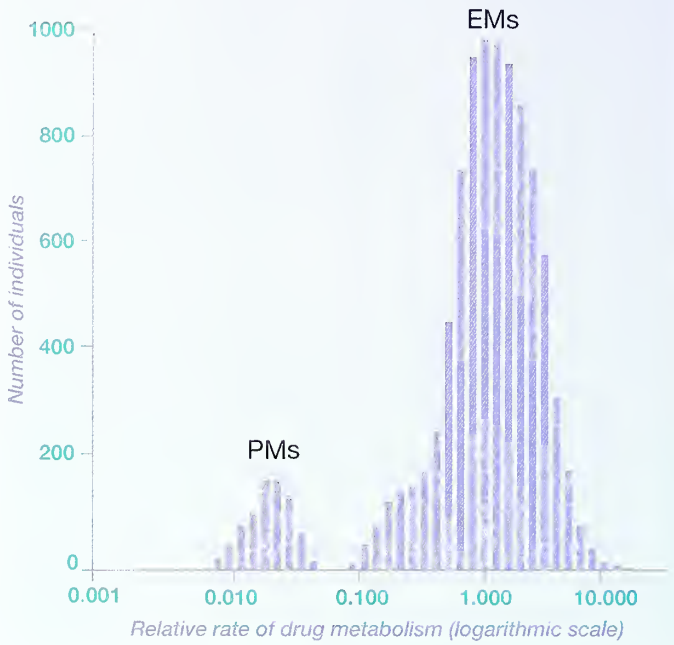
YMBALTA®* ABBREVIATED PRESCRIBING INFORMATION (DULOXETINE)
resentation Hard gastro-resistant capsules, 30mg or 60mg of duloxetine. Also contains sucrose. **Uses** Treatment of major epressive episodes. **Dosage and Administration** Starting and maintenance dose is 60mg once daily, with or without food. osages up to a maximum dose of 120mg per day, administered in evenly divided doses, have been evaluated from a safety erspective in clinical trials. However, there is no clinical evidence suggesting that patients not responding to the initial ecommended dose may benefit from dose up-titrations. Therapeutic response is usually seen after 2 – 4 weeks. fter establishing response, it is recommended to continue treatment for several months, in order to avoid relapse. hen discontinuing after more than 1 week of therapy, the dose should be tapered over no less than 2 weeks before iscontinuation, generally reducing the treatment to half-dose or alternate day dosing, and accounting for individual patient rcumstances, such as duration of treatment and final dose **Contra-indications** Hypersensitivity to any of the components. ombination with MAOIs. Liver disease resulting in hepatic impairment. Use with potent inhibitors of CYP1A2, eg, uvoxamine, ciprofloxacin, enoxacine. Severe renal impairment (creatinine clearance <30ml/min). Should be used in regnancy only if the potential benefit justifies the potential risk to the foetus. Breast-feeding is not recommended. **recautions** Use in children or adolescents is not recommended. Until more efficacy data are available, use in the very lderly population (>75 years) is not recommended. Use with caution in patients with a history of mania, bipolar disorder, r seizures. Caution in patients with increased intra-ocular pressure, or those at risk of acute narrow-angle glaucoma. In atients with known hypertension and/or other cardiac disease, blood pressure monitoring is recommended as appropriate. aution in patients taking anticoagulants or products known to affect platelet function, and those with bleeding tendencies. yponatraemia has been reported rarely, predominantly in the elderly. Depression is associated with an increased risk of uicidal thoughts, self-harm, and suicide. As with other drugs with similar pharmacological action, isolated cases of suicidal deation or behaviours have been reported during therapy or early after treatment discontinuation. Close supervision of high-sk patients should accompany drug therapy. Patients, (and caregivers) should be alerted about the need to monitor for the mergence of suicidal ideation/behaviour or thoughts of harming themselves and to seek medical advice immediately if nese symptoms present. Since treatment may be associated with sedation, patients should be cautioned about their ability o drive a car or operate hazardous machinery. Duloxetine is used under different trademarks in several indications (major epressive episodes as well as stress urinary incontinence). The use of more than one of these products concomitantly hould be avoided. **Interactions** Caution is advised when taken in combination with other centrally acting medicinal roducts and substances, including alcohol and sedative medicinal products; exercise caution when using in combination vith antidepressants. In rare cases, serotonin syndrome has been reported in patients using SSRIs concomitantly with erotonergic products. Caution is advisable if duloxetine is used concomitantly with serotonergic antidepressants like SSRIs, ricyclics, St John's Wort, ventafaxine, or triptans, tramadol, pethidine, and tryptophan. Undesirable effects may be more ommon during use with herbal preparations containing St John's Wort. *Effects on other drugs:* Caution is advised if o-administered with products that are predominantly metabolised by CYP2D6 if they have a narrow therapeutic index. **Undesirable Effects** The majority of common adverse reactions were mild to moderate, usually starting early in therapy, nd most tended to subside as therapy continued. Those occurring at a rate of >2% and significantly different to the placebo ate, or where the event is clinically relevant are: Very common (≥ 10%): Nausea, dry mouth, and constipation. Common ≥ 1% and <10%): Appetite decreased, weight decreased, insomnia, libido decreased, anorgasmia, dizziness, somnolence, remor, blurred vision, hot flushes, diarrhoea, vomiting, sweating increased, erectile dysfunction, ejaculation delay or disorder, fatigue. Dizziness, nausea, insomnia, headache, and anxiety were also reported as common adverse events, particularly upon abrupt discontinuation. In trials, treatment was associated with numerically significant, but not clinically related, increases in ALT, AST, and creatinine phosphokinase. These transient, abnormal values were infrequently observed compared with placebo-treated patients. Duloxetine is known to affect urethral resistance. In placebo-controlled trials, urinary hesitation was reported rarely (<1%) in male patients. If symptoms develop during treatment, consideration should be given that they might be drug-related. Cases of suicidal ideation and suicidal behaviours have been reported during duloxetine therapy or early after treatment discontinuation. ECGs evaluated during the clinical trials demonstrated no difference in QTc intervals in duloxetine-treated patients compared with those on placebo. There is limited clinical experience of overdose with duloxetine. No fatal overdose was demonstrated, including doses up to 1400mg either alone or in combination with other medicinal products. No specific antidote is known but routine monitoring and appropriate symptomatic supportive measures should be used, including, if appropriate, early gastric lavage or activated charcoal.
For further information see Summary of Product Characteristics, which is available at http://emc.medicines.org.uk/.
Legal Category POM **Marketing Authorisation Numbers** EU/1/04/296/001 EU/1/04/296/002 EU/1/04/296/003
Basic NHS Cost £22.40 per pack of 28 x 30mg capsules. £27.72 per pack of 28 x 60mg capsules.
£83.16 per pack of 84 x 60mg capsules.
Date of Preparation or Last Review December 2004
Full Prescribing Information is Available From Eli Lilly and Company Limited, Lilly House, Priestley Road, Basingstoke, Hampshire, RG24 9NL Telephone: Basingstoke (01256) 315 999
*CYMBALTA (duloxetine) is a trademark of Eli Lilly and Company.
DDP214/Dec 2004

new Cymbalta® duloxetine

because depression hurts

Boehringer Ingelheim Lilly

Figure 2: Bi-modal distribution of CYP2D6 drug metabolism activity in a typical European population, which segregates into poor metabolisers (PM) and extensive metabolisers (EM) as a result of genetic polymorphism



juice effect is CYP3A4-specific it can alter the plasma ratio between different metabolites of a drug if some of these are not formed by CYP3A4. Thus with omeprazole, grapefruit juice decreases omeprazole sulphone (formed by CYP3A4) relative to 5-hydroxyomeprazole (formed by CYP2C19).

Suppose this were to occur with a drug that relied for its therapeutic effect on a major, pharmacologically active CYP3A4 metabolite but which was also metabolised by a different CYP (not affected by grapefruit juice) to a metabolite that was toxic. If the dose was increased to counter the grapefruit juice effect on the formation of the therapeutic metabolite, this could uncover unexpected adverse effects from the simultaneous formation of abnormally high levels of the toxic metabolite.

Grapefruit juice exemplifies a third type of CYP inhibition – 'mechanism-based' or suicide inhibition – in which chemicals are converted by CYP to metabolites that bind permanently to the CYP and either trap it in a non-functional state or damage it structurally. This type of inhibition is very enduring and can persist even after the plasma contains no remaining traces of the drug that caused it ('Exocet inhibition', that is, fire and forget). It is overcome only following biosynthesis of new, undamaged CYP molecules in the absence of the drug.

Because of this, the grapefruit juice effect can persist for three days. Long-lasting mechanism-based inhibition of CYPs is also caused by several drugs, including diltiazem, Ecstasy, fluoxetine and ritonavir.

Herbals

St John's wort is popularly self-administered to treat depression. Long-term administration (such as 300mg thrice daily for 14 days) induces CYP3A4, possibly due to a constituent, hyperforin, potently activating the PXR induction receptor for CYP3A4.

This might result in decreased therapeutic efficacy or an increased dose requirement for drugs metabolised by CYP3A4, including ciclosporin and indinavir. St John's wort also induces CYP2B6 but not CYP1A1, CYP2C9 or CYP2D6. The herb can inhibit several human CYPs *in vitro* but might not do so *in vivo*.

Several herbs inhibit CYPs, although mostly only *in vitro* to date. Nonetheless it is irresistible to speculate that their claimed therapeutic and chemopreventative properties might in part be due to inhibition of the CYP metabolism of toxic physiological or dietary compounds.

Kava and ginkgo biloba inhibit various human CYPs *in vitro*. Kava is hepatotoxic and this might be exacerbated in CYP2D6 PMs. Garlic contains diallyl sulphide, which strongly inhibits CYP2E1 (instrumental in the liver toxicity of paracetamol overdose). Ginseng inhibits CYP1A2, which can convert chemicals in grilled meat to carcinogenic metabolites. Goldenseal and valerian may inhibit CYP3A4. Chemicals in pepper and liquorice inhibit CYPs. Cranberry juice inhibits CYP2C9 metabolism of warfarin, potentially resulting in haemorrhage. Flavonoids, terpenoids, polyphenols, alkaloids and anthraquinones are widespread herbal and dietary chemicals that can inhibit or induce many CYPs.

However, not all grapefruit juice or herb-drug interactions involve CYPs. Several are likely to involve herbal modulation of transport proteins that 'pump' drugs across intestinal cells, either into the blood or back into the intestinal lumen. Gingko biloba can cause serious bleeding in patients on warfarin, but probably because it contains gingkolide B, a potent inhibitor of platelet activating factor.

Smoking

Nicotine is rapidly inactivated by CYP2A6. It follows that CYP2A6 polymorphism may be a major determinant of smoking habit and that a CYP2A6 deficiency, whether genetically based or due to inhibition by drugs or diet, might result in higher blood levels of nicotine and a decreased need to smoke. Science thrives on disagreements between experts, however, and others refute this.

Alcoholic smokers might respond abnormally to centrally acting drugs because in their brains a different CYP, CYP2B6, is elevated.

Liver function

Hepatic CYPs are decreased in chronic liver disease, but not all CYPs equally. This can change the likelihood of drug-CYP interactions. For example, in most patients lidocaine metabolism is mainly by CYP1A2 and inhibited by fluvoxamine, but in chronic liver disease CYP1A2 is extensively decreased, CYP3A4 takes over lidocaine metabolism and fluvoxamine is far less inhibitory.

CYPs play a role in some types of drug-induced liver injury by converting a drug to toxic metabolites that directly attack liver cells, for example, CYP2E1 in paracetamol overdose. On the other hand, certain types of drug-induced hepatitis are caused by auto-antibodies produced against the form of CYP that metabolises the drug. Examples are hepatitis caused by hydralazine, tienilic acid and halothane, due to auto-antibodies against CYP1A2, CYP2C9 and CYP2E1 respectively. Auto-antibodies against CYP2D6 are associated with auto-immune liver damage.

Sex differences

It is unclear whether CYP-dependent drug interactions or CYP polymorphisms are different in women compared with men. Women clear several drugs that are metabolised by CYP1A2 less than men and by CYP3A4 more than men. There is disagreement, however, as to whether hepatic CYP3A4 and CYP1A2 levels are different between the sexes, but consensus on an absence of major sex differences in CYP2C9, 2C19 and 2D6 metabolism.

Disease

Children undergoing chemotherapy for acute lymphoblastic leukaemia have a poorer prognosis if they have a specific genetic variation in CYP1A1, while mutations in the CYP1B1 gene are associated with early-onset and primary congenital forms of glaucoma.

To end with one more speculation: the CYP1B1 enzyme occurs almost exclusively in cancer cells. It may therefore provide new methods of detecting cancer, of preventing it (by the metabolism of dietary chemicals, such as resveratrol in wine, to anticancer compounds), and of curing it (by the activation of anticancer prodrugs inside cancer cells, thereby lessening toxic side effects to the rest of the body).

Bibliography:
This is limited to articles that are freely available on the internet without the need to access a university or hospital library. Available on request.

Danny Burke is emeritus professor of pharmaceutical metabolism at the University of Sunderland and has published over 200 research articles on CYP and drug metabolism.

Less SSRI use could raise suicide rates

Limiting SSRI prescriptions in light of recent regulatory actions may increase death rates from untreated depression, say researchers from the USA.

The researchers claim that suicide rates have fallen since SSRIs were introduced and that this could be reversed with stricter prescribing regulations.

They claim that studies have shown that suicide victims were more likely to have untreated depression than a link between SSRIs and their death.

However, they warn that patients being prescribed antidepressants for the first time but then not being seen by the GP for a couple of months leaves them exposed to a suicide risk. "When people start antidepressant therapy, the first symptom to be alleviated is low energy, but the feeling that life isn't worth living is the last to go," says Julio Licinio, psychiatry professor.

"As they begin drug therapy, they experience more energy, but still feel that life isn't worth living. That's when a depressed person is most in danger of committing suicide."

For more information:

Nature Reviews Drug Discovery 2005; 4:165-71

Depressed people are most in danger of committing suicide when they begin drug therapy, researchers say

Death link query over Reminyl

A study has linked Reminyl (galantamine hydrobromide) to slightly higher mortality rates when used in patients with mild cognitive impairment, a currently unlicensed indication.

The trial found that patients with mild cognitive impairment taking galantamine had a higher mortality rate than patients receiving placebo. Johnson & Johnson, which markets the drug everywhere except the UK, where Shire has marketing rights, says it is currently analysing data from these studies and discussing the results with regulatory authorities.

The study was designed to monitor the rate of progression from mild cognitive impairment to dementia in patients taking the drug.

NICE advises on osteoporosis

An osteoporosis charity says it is "broadly satisfied" with NICE's latest guidelines on drug treatments for the bone condition.

The National Osteoporosis Society says it believes "much has been achieved" with the new guidelines. NICE has recommended that some postmenopausal women who have had a bone fracture can receive bisphosphonates to prevent secondary fractures.

Women eligible for bisphosphonates include those aged 75 and older, aged 65 to 74 with confirmed osteoporosis, or under 65 with very low bone mineral density or with confirmed osteoporosis and another risk factor.

Women who cannot take bisphosphonates, who have had a poor response to them or physically cannot comply with the special usage recommendations are eligible for raloxifene (Evista).

Women who are aged 65 and over, are intolerant of bisphosphonates or experienced a poor response and have an extremely low BMD or a very low BMD and another risk factor are eligible for teriparatide (Forsteo).

The NICE guidelines recommend bisphosphonates to prevent secondary fractures in some women

Scriptlines

Four ED appliances in DT

iMedicare has announced that four of its products for erectile dysfunction will be in Part IXA of the *Drug Tariff* from February 1.

They are: SomaErect Response II, SomaErect Touch II, Assist Erection Maintenance System, and SureEase Erection Maintenance Ring Set.

For more information:

See *Price List*
iMedicare
Tel: 020 8207 627

Neogest and Logynon

Schering Health Care has announced it is discontinuing Neogest tablets (DL-norgestrel 75mcg) and the Logynon tablets Clinic Pack (ethinylestradiol and levonorgesterel).

The company estimates that current stock levels can support demand for Neogest until May 2005 and Logynon Clinic Packs until August 2005.

Logynon will continue to be available in patient packs (3 x 21 tablets).

For more information:

Schering Health Care
Tel: 01444 232323

Aventis product orders

All orders for Aventis products should now be sent to Sanofi-aventis's Guildford office at 1 Onslow Street, Guildford,Surrey GU1 4YS.

Orders for Aventis and Sanofi-Synthélabo should be kept separate until further notice to prevent delivery delays.

Distriphar brands should continue to be ordered from Aventis's West Malling office until further notice.

For more information:

Sanofi-aventis
Tel: 0800 854430

Microgynon 30

Schering has announced that a new pack size for Microgynon 30 tablets: (levonorgesterel 150mcg, ethinylestradiol 30mcg) will replace the single cycle pack.

Price: £2.85

Pack size: 3 x 21 tablets
Pip code: 310-8909
Schering Health Care
Tel: 01444 242424

Formance supply problems

Abbott Nutrition has announced a temporary cessation in supply for Formance, its dessert style products for dysphagia patients.

This is due to Abbott transferring its production sites. As yet, Abbott does not know when supply will recommence, but will announce it later. The company says that patients who receive Formance should consult their GP or dietitian about finding a suitable alternative.

For more information:

Abbott Nutritional Services
Tel: 0800 252882

Clairol promotes winning streak

Procter & Gamble is set to roll out an instant-win on-pack promotion with its Nice 'n Easy colourant product under the Clairol brand.

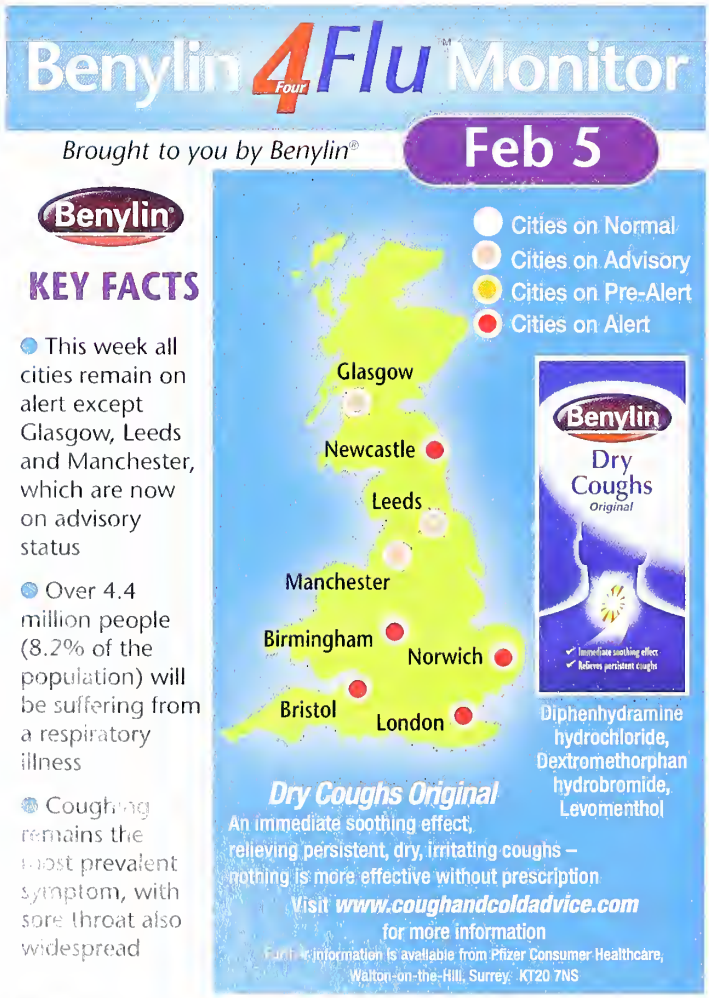
The promotion, to be launched on February 14, will only be available to the pharmacy sector.

The on-pack promotion will be placed on 150,000 packs, at the recommended retail price of £4.49. The top prize is £10,000, as well as three £1,000 wins, three £500 wins and 500 £10 wins.

Paul Lettice, Procter & Gamble's trade marketing manager, said: "Nice 'n Easy is a high performer in the pharmacy sector and this instant-win on-pack promotion is an exclusive from Clairol to reward their success and to drive brand share even higher."

Procter & Gamble is supporting Clairol's Nice 'n Easy with a £2 million marketing campaign between January and June 2005.

For more information:
Procter & Gamble UK
Tel: 01932 896 000



Allens sticks to traditional roots

Allens Healthcare has relabelled its Allens Pine & Honey Balsam cough and cold remedy.

Allens managing director, Howard Dixon, said: "The new label for Pine & Honey Balsam will keep the key elements of its original traditional image but the branding will be stronger and product benefits clearer."

The remedy is now available via MST, and Palmer & Harvey will also supply the product from the beginning of March.

Price: £2.65 (150ml)
Pip code: 094-7481
Allens & Co (Anglesey) Ltd
Tel: 01484 519 251

Bisodol goes live on the net

Forest Laboratories has launched a website for its recently acquired heartburn and indigestion brand, Bisodol.

The website contains information for sufferers of heartburn and indigestion, including a "Hints & Tips" section, as well as links to other healthcare websites.

Forest is also boosting promotional support for the Bisodol brand with a television, press and outdoor advertising campaign and a money-off coupon sent out via *Reader's Digest* from January to September 2005.

For more information:
Forest Laboratories
Tel: 01322 550 550
www.bisodol.com

Lynx kicks off with kung-fu ads

Unilever UK Home and Personal Care is supporting its new Lynx brand fragrance with a Far Eastern inspired advertising campaign.

Adverts for Lynx Unlimited will be screened in cinemas from February 4 and on television from February 7 with the strapline: "For unlimited powers of seduction."

There will also be a poster, press, online and sampling campaign, as part of a £15 million advertising budget for the Lynx brand.

For more information:
Unilever UK Home and Personal Care
Tel: 020 8439 6100

Cleaner teeth with seaweed

A Swedish oral tablet made from seaweed claimed to improve oral hygiene is being introduced to UK pharmacies.

PlaqueOff, which was discovered and developed by a dentist, showed reductions in tartar levels by up to 68 per cent and reductions of plaque levels by up to 87 per cent in clinical trials, the Swedish manufacturer, ProDen, claims.

The tablet is made from the *Ascophyllum Nodosum* family of seaweed and contains no artificial colours, preservatives, gluten or sugar. The manufacturer says improvements can be seen within five to eight weeks. PlaqueOff is distributed in the UK by Molar Ltd.

Price: £15.99
Pack size: 120 tablets (three months supply)
Molar Ltd
Tel: 01934 710 022

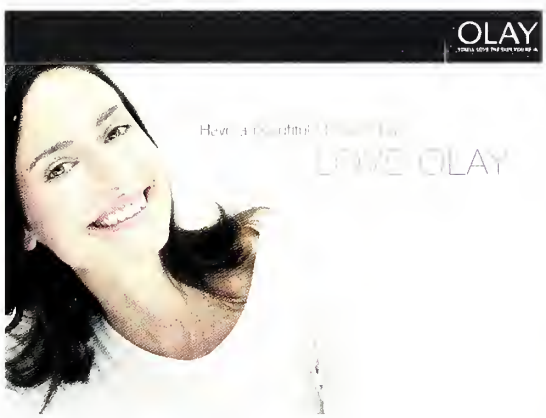
Olay in radio drive for Mother's Day profits

Procter & Gamble is hoping to boost Mother's Day profits for its Olay brand by launching a radio campaign.

It will cover all Olay product categories and will have the theme: "Have a beautiful Mother's Day with Olay."

Procter & Gamble is spending double last year's March advertising budget on the 2005 Mother's Day campaign and have already taken television adverts in February for Olay's Regenerist and Total Effects sub-brands.

For more information:
Procter & Gamble UK
Tel: 01932 896 000



Boots and Moss to take Grafton

Grafton International will distribute the Badger Balms brand through Boots. Four lines of aromatherapy based organic balms – Healing Hands Balm, Sore Muscle Rub, Sleep Balm and Foot Balm -- will be available in 335 Boots stores from April.

Boots has a six-month exclusivity contract for the product, but this could be negotiated further if it chooses to take more lines, a spokesperson for Grafton said.

The balms will be placed in the Alternative Health section, retailing at £3.99 each.

Grafton will also supply 600 Moss Pharmacies with Naturally Fresh Deodorant Crystals.

Three lines – the Twist Up stick, Spray Mist and Roll On – will be available from May this year.

The deodorant crystals kill the odour-causing bacteria and should be used by those allergic or sensitive to conventional deodorants, Grafton says.

Price: Badger Balms £3.99; Naturally Fresh Deodorant Crystals £2.95
Pip codes and pack size: see *Price List* for details

Lil-lets expands with pantliners

Accantia Health & Beauty Ltd is extending its Lil-lets brand by adding pantliners to the range.

They are available in two sizes: normal (in packs of 18) and large (in packs of 28) from last month.

The company says the pantliners have a breathable format and will guarantee comfort with a silky smooth cover.

Lil-lets applicator tampons are also being re-packaged to increase awareness and appeal to a younger audience. The new packaging, which has been on the shelves from this January, will have a more contemporary, vibrant design that will communicate more clearly that they are applicator tampons, Accantia says.

Jackie Roberts, brand manager, said: "Lil-lets has always been synonymous with non-applicator tampons. This new eye-catching packaging for our applicator tampons will increase awareness of the range."

Price: Normal (18 folded and wrapped) £0.99; Large (28 flat liners) £1.79
Pip code: Normal 313 1018
Large 313 1000
Accantia Health & Beauty Ltd
Tel: 0121 327 4750

New formula for Gaviscon

Reckitt Benckiser is launching a reformulated Gaviscon dispensing tablet – Gaviscon Advance – and will discontinue the current dispensing version.

Gaviscon 500mg tablets in lemon and peppermint flavour are being withdrawn as a result of an EU directive that required manufacturers to stop making products using isopropyl alcohol in the process by the end of 2004.

The new formulation Gaviscon Advance tablets will be available in peppermint flavour from February 1, priced £7.49 for a dispensing pack of 60 tablets. OTC products will not be affected.

To switch patients to the new tablets GPs should write 'Gaviscon Advance tablets'.

Price: £7.49
Pack size: 60 tablets
Pip code: 309-2244
Reckitt Benckiser Plc
Tel: 01482 326 151

TV

Sponsored by KOOLn' SOOTHE

Aquafresh: All areas except U, CTV, GMTV
Audiclean: C4, GMTV
Bassett's Soft & Chewy Vitamins: GMTV, Sat
Bisodol: Sat
Covonia: five, GMTV, Sat
Haliborange Omega 3 for Kids: C4, GMTV, Sat
Horlicks: All areas except U, CTV, GMTV
Kool 'n Soothe: All areas except C4, Sat
Kool 'n Soothe Migraine: All areas except C4, Sat
Lucozade Hydro: All areas except U, CTV, GMTV
Multibionta: C4, Sat
NiQuitin CQ: All areas except CTV, GMTV
Nytol: All areas except U, CTV, GMTV
Olbas range: five, GMTV, Sat
Palmer's Cocoa Butter Formula: C4, Sat
Sensodyne: All areas except U, CTV, GMTV
Seven Seas Cod Liver Oil: All areas
Soothagel: GMTV
Sudafed: All areas except U, GMTV
Voltarol Emugel P: B, G, Y, C, A, HTV, W, M, LWT, TT
Zovirax: C4, five, Sat

PharmaSite for next week: Nicotinell – window, **Fluconazole** in-store **Nicotinell** – dispensary

Pharmacy Channel: Beechams and **Night Nurse**

A-Anglia, B-Border, C-Central, C4-Channel 4, Five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Paradise gained?

Pharmacists attending the Numark Conference in Mauritius this week discussed the new pharmacy contract, medicines, IT and CPD in the opening session on Tuesday morning. Charles Gladwin reports

Pharmacists should not expect to see too much commissioning of third tier services in the first year of the new pharmacy contract, Musa Dhalla has warned.

However, while there would not be a "flurry of commissioning", Mr Dhalla said that this did not mean things were not moving forward.

Mr Dhalla, of Webstar Health, has been involved in the drafting of the pharmaceutical needs assessment (PNA) process that PCTs will use to determine the level of provision and need for pharmaceutical services. The PNA will also indicate how willing, as well as how able, pharmacists are to take on the new services if commissioned.

The survey may also prompt them to ask if community pharmacies are not providing a service, why? Is a service being provided by another agent and how appropriate is this, for example?

Musa Dhalla

Pharmacists should ask themselves, too, what experience they have in delivering a particular service, of conducting interviews with patients, of interacting with other health professionals, said Mr Dhalla. He pointed out that not all services are equal: they are not all paid for in the same way or delivered in the same way. By deconstructing a service to see how easy it is for a pharmacist to provide, it will go some way to determining how willing the pharmacist is to provide it. Pharmacists should consider what sort of facilities their pharmacy has and what skills they and the pharmacy staff have. It might mean, for example, that a pharmacist in a small pharmacy may be better suited to providing off-site services such as domiciliary visits or medication reviews. "You have to adapt the services you want to provide to your circumstances," he said.

But he warned: "I do not think that we as pharmacists will be able to provide those services as efficiently as they [the PCTs] may wish until we have the IT links. That will take a few years but when it does come on stream, we will do it very efficiently."

Delegates' feedback included:

- Pharmacists should encourage their PCT to give a breakdown in their remittance advice of how the remuneration has been calculated to ensure that they are not missing payments for commissioned services.
- Pharmacists may want to question the value of care home medication reviews. A feeling among North Somerset contractors is that despite having been trained by the PCT to provide these services, GPs are not always taking up the pharmacists' recommendations in adjusting patients' medication or doses. It gives the impression this is a box ticking exercise for GPs so that they can claim payment under the General Medical Services contract.
- A pharmacist who underwent repeat dispensing training four months ago has yet to see a repeat prescription. "We did the training with GPs but until we get the IT, I do not think the system will work."
- PCTs should remember that GP surgery staff need to be trained in the new pharmacy services, particularly if they link in with any GMS services.
- Now that many GP surgeries do not open on Saturdays, Dorset pharmacists are being encouraged to use the day to conduct medication use reviews with patients. It is also an opportunity to develop minor ailment services and for pharmacists to provide aspects of healthcare that GPs would otherwise normally provide, said Roger King.

Parallel importers may look to P medicines

Parallel importers may start to bring in P medicines to respond to increasing pressures being put on prescription products.

Paul Bottomley, commercial director for Dowelhurst, said that the recent re-negotiation of the Pharmaceutical Prices Regulation Scheme had led to PI companies being targeted by the main manufacturers. "We feel there has been a very strategic move to go after the PI houses," he said. "We have seen some significant impacts with them trying to reduce PIs."

Manufacturer-instigated quotas are a big problem for the UK PI industry. He accused "big pharma" of "flagrantly not complying with the free movement of goods" requirements of the European Union. The manufacturers are introducing quotas on a country by country basis, only releasing a certain amount of stock to meet that country's needs. "Stock is being increasingly restricted and people are starting to capitalise on this by putting up prices so that the highest bidder wins," he said.

Manufacturers are also increasingly cutting out wholesalers in some countries, he claimed, and supply is being made directly to pharmacies.

Mr Bottomley was also critical of the PI licensing system in the UK, saying it was "loaded against us". It takes 12 to 18 months for the MHRA to grant a parallel import licence in the UK, but elsewhere in Europe the time required to issue a licence is between two and six weeks. There are about 600 licence applications with the MHRA, he said (although another 600 or so have been cancelled).

These factors, as well as the pound devaluing against the euro, mean that 25 per cent of PI licences are no longer viable, he said. Combined with a further reduction of 25 per cent in margins, overall PI sales are down 30 to 35 per cent. "We are looking at P medicines as part of PIs," he said, although he pointed out that his company has cancelled its licence application for Zocor (simvastatin) as sales had not impressed him sufficiently to make it worth the licence fees.

He suggested that the manufacturers' actions are being driven by the USA which could deregulate its own market. As it represents 55 per cent of the world's drug bill, the US administration may want to reduce the drugs bill by allowing PIs, including from the UK. "There is a big agenda to protect the US market at all costs," he said.

Implications for IT

Mimi Lau

Pharmacists should no longer be using DOS-based or DOS for Windows based systems, said David Wood, chief executive of Numark.

"You will need an up-to-date system that is not DOS-based as these will not be compliant. There's a lot of systems still running on DOS-Windows," he said. He acknowledged that it was difficult for contractors to know which of the pharmacy computer systems to choose ahead of details of the IT systems being agreed and published, but he encouraged users of DOS systems to start upgrading now. He said that Numark would advise members individually of the suitability of the six computer suppliers' systems as the systems differ.

Mimi Lau, Numark's professional services controller, said that they had been assured by the systems suppliers that the introduction of the new computer systems would be on a 'level playing field' for independent and multiple pharmacies alike. "I would encourage those pharmacists with old systems to upgrade quite quickly," she said. Numark is sending out a questionnaire this week to its members to assess IT preparedness.

Concerns from the floor about the timescales given in the National Plan for IT (NPfIT) for the introduction of ETP and other IT systems prompted the chief pharmaceutical officer for England, Jim Smith, to agree that the targets are "challenging". They were set two years ago, he said, adding: "The whole IT programme is challenging... but there is massive determination in the DoH to make it succeed."

While pharmacists in England can expect a one-off payment in 2004-05 for the introduction of ETP (under certain criteria), Dr Smith said that PSNC would need to discuss payment for ongoing IT maintenance or replacement costs with the DoH.

David Wood

PPRS across Europe

Other parts of Europe are introducing forms of PPRS. Holland and Belgium introduced new systems on January 1, and Italy and Spain brought in new measures from February 1. Italy had been looking to reduce the price of the 180 top products by 13 per cent, while Spain has had a blanket reduction of 4 per cent. Medicines packaging in Spain has the price printed on it. The introduction of a 4 per cent price cut from February 1 means that stock in Spain is being returned to manufacturers to have the price reprinted. This means that PIs from Spain will be in short supply over the next month.

At October community conference pharmacist **David Morgan** spelt out some home truths about what it was like working as a locum. In this article David looks to the future and how things might be better

Ray of hope?

The new contract for community pharmacy undoubtedly heralds the biggest change in the way pharmacy is practised since the birth of the National Health Service in 1948.

Many have welcomed the proposals as at last recognising the skills that exist in the profession, previously untapped or unacknowledged. Others are much more cautious and are guardedly awaiting the implementation of the proposals before forming a definitive view. Such is the scale and scope of the proposals that no one can be quite sure how the profession as a whole will cope with the many extra responsibilities placed upon it, and there is undoubtedly a great deal of finger crossing going on in PSNC, Lambeth, St Albans and elsewhere.

Many of the concerns already expressed, especially by smaller contractors, will hopefully be ironed out in the weeks ahead. A lengthy bedding-down period should be allowed to take place after April 1 before forming a definitive view of what mutual benefits have accrued to the three partners in the exercise – community pharmacy, the Government, and most importantly of all, the public. It is the latter who should be at the heart of our thinking when discussing how pharmacy practice is adjusting to providing new levels of service to our communities and patients.

Pharmacists' interpersonal skills and ability to communicate will need to be honed and improved to allow effective delivery of the new services and it will be more important than ever that professional standards in pharmacy are raised to a higher level to allow this to happen.

Premises will need to be smartened up, especially in areas to which the public will now have access. Cleanliness and tidiness will need to improve, clutter be removed and general hygiene standards raised in all areas of the pharmacy. Pharmacists and their staff will have to appear suitably dressed in appropriate uniforms or apparel at all times. If this means the end of the scruffy, cardiganed pharmacist looking as if a good wash would do him or her good, so much the better.

It is no use hoping to deliver better professional standards to the public if the pharmacist, the staff or the premises do not look capable of achieving it. This means that just about every set of premises should be looked at and the appropriate improvements implemented where necessary.

PCTs will have a vital role in assessing standards as never before and accreditation will afford the opportunity to raise them across the board. I have commented before on the lamentable state of many pharmacies and one of my main hopes for the future must be that this situation can and will be improved. Employers, both corporate and private, must realise that it will make increasing commercial sense to further invest

in their businesses to take advantage of the new opportunities and income streams becoming available.

It will be necessary for PSNC and the Government to jointly ensure that implementation of the new contract makes both commercial sense to the employers, as well as professional sense to the other parties. If the cost of any extra investment outweighs the likely benefits, then a real problem could arise which could throw into sharp contrast those companies genuinely interested in raising standards to deliver extra services to the public and those run by accountants only interested in the bottom line.

If finance directors see little commercial benefit in implementing in full the new contract proposals and see a drop in prescription income, then some may feel their loyalties lie more with their shareholders than the Government.

The implementation of Standard Operating Procedures – to say nothing of the disciplines involved in what many see as onerous time-consuming Continual Professional Development (however laudable the objectives) – worries many pharmacists. Concerns exist that the imposition of so much change on top of the heavy burden of their present responsibilities in running their pharmacies on a day to day basis, which too many already find stressful and physically tiring, will lead to a high burn-out rate and a high turnover of managers and many, especially female pharmacists, opting for a less stressful career, possibly outside pharmacy.

Just dumping extra responsibilities on already overworked and overstressed staff is just not an option, and head offices, chief executives and directors must be made aware of this important point. Many branch staff, particularly managers, have expressed enormous concern that they will be expected to cope with all the extra responsibilities that 2005 will bring. They will have no extra staff or support to assist them, and will be under constant pressure from head and area office to deliver the financial benefits which senior executives assume are there to be made. All with little or no increase in salary or rewards, of course.

Working as a locum I want to be involved as a full partner in delivering all aspects of the new contract and when one looks at the increasing number of pharmacists working as locums I cannot help but feel that we need more recognition and training by employers to make our full contribution. Just hammering out labels on a computer and checking prescriptions while someone else does the more professionally rewarding parts of the job is not my idea of becoming fully involved, someone please note.

There is undoubtedly a great deal of finger crossing going on in PSNC, Lambeth, St Albans and elsewhere

Just hammering out labels on a computer and checking prescriptions while someone else does the more professionally rewarding parts of the job is not my idea of becoming fully involved, someone please note

Perhaps we need our own association of locum pharmacists to enable us to express our own views and opinions instead of being either unrepresented as a group or just lumped in with everyone else. Nearly every discipline within pharmacy has its own organisation these days – why not locums too, since we now form such a large percentage of pharmacy manpower?

In 12 months' time I expect that community pharmacy will have effectively split three ways, with the bulk of pharmacies simply delivering basic essential services with little scope or ability to deliver anything else. This will inevitably lead to a drop in revenue from prescription income, partly mitigated by the movement of some POM lines to P, but again more P lines will move to GSL so this benefit may be limited.

Probably no more than 20 per cent of pharmacies will be able to deliver the middle tier of advanced services, and even fewer will be 'super pharmacies' equipped, staffed and qualified to ensure the full range of enhanced services are available to the public.

The hope must be that with a general raising of standards some pharmacies will be able to progress to a higher grade but again the Government must understand that in dividing up the cake to ensure that some get more, inevitably others get less. I see little evidence that anyone has addressed the anomaly of a glut of competing pharmacies in the urban centres, which will be added to by the opening of more supermarket pharmacies, compared to the dearth of pharmaceutical services in more rural areas.

The new contract will have little impact on this situation and I am also unsure how much pharmaceutical services delivered by dispensing doctors will be affected by certain aspects of the new contract. Over everything and everyone lurks the dark shadow of a constantly cost-cutting Treasury, only too ready to see the drug bill reduced and seemingly oblivious to the knock-on effect that their policies could have on the delicate balance between financial viability and going out of business.

However, I steadfastly refuse to be downcast. We are undoubtedly on the brink of a brave new world for community pharmacy but it is up to everyone to ensure that the opportunity is recognised and taken. To a greater extent than ever before, the future is now in our own hands. We must all play our part in achieving the goal which so many have worked so hard to achieve – a fully professional community pharmacy, recognised and respected by all. We may never get such an opportunity again.

David Morgan is a former pharmacy owner who now locums in the South East of England.

What are your views on what the future holds? Do you think the points David Morgan makes are valid? Let us know – send you comments to *C&D*, Sovereign House, Sovereign Way, Tonbridge, Kent TN9 1RW or e-mail to *chemdrug@cmpinformation.com*. Fax: 01732 367065.

A pharmacy

A round table discussion about the new pharmacy contract is being issued on CD-Rom with this week's *C&D*

The CD-Rom 'Pharmacy Vision' is accredited for four hours' learning with the College of Pharmacy Practice

The new contract for community pharmacy completes the most radical shake up in the delivery of health services in the UK since 1948.

This is the view of Simon Fradd, GP, chairman and founder of the Developing Patient Partnerships organisation. He chaired the discussion which included John Chisholm, past chairman of the BMA's GP committee, Chris Towne, lead negotiator of the NHS Confederation, Sue Sharpe, PSNC chief executive, and Steven Williams, pharmacy contractor and member of the PSNC negotiating team.

Sue Sharpe set out the four main themes of the new contract: "The first one is using the fact that people come into community pharmacies as patients and as members of the general public to really use community pharmacy to encourage people to take better care of their own health, to help deliver the Government's health promotion and public health targets.

"The second area is building on the support for self-care that community pharmacies already provide and ensuring that they use that ability to really divert resources away from other parts of the primary care family." This will mean encouraging people more and more to use the pharmacist, and to help build people's confidence in coping with minor ailments.

"Then we have the really exciting new use of community pharmacists' skills in chronic disease management and the medication use reviews that pharmacists will be undertaking. "This will be an increasing role, ensuring the patients are getting the best from their medicines. "That is the really exciting new clinical role for the community pharmacist and we expect in time that prescribing roles would develop from that.

"The fourth area is to help the NHS manage and cut down on the waste medication that, at the moment, is really such a sap of NHS resources and so unnecessary."

For the NHS, Mr Towne said: "We were looking for something that was going to be good for patients, good for pharmacists, good for PCTs in terms of delivering the agenda that they're trying to deliver at the moment, and obviously good for general practice. We were obviously very aware that this was an opportunity to help with some of the workload issues in general practice."

Dr Chisholm said that the new general medical services contract has been in place since April 2004. "It's an enormous change and given that one of the triggers for that contract was the excessive workload in general practice, unsurprisingly we envisage pharmacists taking on additional roles really as part of our contract in terms of medicines management, health promotion, prescribing, the management of minor self-limiting illness and chronic disease management. The two contracts really do fit together very well."

Asked if pharmacists can really deliver the new contract, Mr Williams said that community pharmacy has to recognise it as a major challenge. "Community pharmacists need to think about how their pharmacies operate at the moment and what changes they could make to the way they operate to put capacity into the system.

"The use of checking technicians is something that I think we'll see increase quite a lot, so that the checking of prescriptions – the actual medicines before they're handed to the patient – is actually done by a technician who has been suitably trained. That will allow the pharmacist to do the pharmaceutical check of the prescription before it's dispensed and to undertake things like medicines use reviews, so checking technicians are one way in which we can increase the capacity within the pharmacy."

vision

A CD-Rom of the discussion has been distributed with this issue of C&D. In addition to the discussion, the CD-Rom contains the new contract handbook. The round table debate can also be accessed via www.theclinicalchannel.tv where a question and answer form can be downloaded for marking by the CPP

Standard operating procedures will also be important: these will mean that pharmacies are operating in a systematic way so that people in the pharmacy know exactly what they need to do at each stage in the process, giving the pharmacist confidence that the system is operating properly.

Dr Fradd pointed out that pharmacists are going to be providing many services which traditionally have been delivered in the GP surgery, such as chronic disease management. This has implications for raising awareness among the public.

Dr Chisholm agreed: "I think there's an educational job in that the public will need information to enable them to make the right sort of choices as to where they access the healthcare system. That's an educational job for doctors, for pharmacists, for nurses but also for facilities like NHS Direct and NHS Direct Online to give people better information to empower them to make the right sort of choices about their own healthcare.

"One of the foundations for that is communication between healthcare providers and that means pharmacists having access to information but also contributing to the patient record, so that then when a patient is perhaps consulting a nurse or a GP on a future occasion, that healthcare professional knows what has happened in the pharmacy. So communication and IT links and education of the public to empower them to make the right choices are all keys to making this work."

Dr Fradd added: "And presumably education of doctors to make sure that they go along with the change and allow patients to go where it's appropriate to get the service?"

"Yes," said Dr Chisholm. "I think that doctors in the main have got past that sort of protectionist attitude of thinking that only they can deliver services. I think the workload problems in general practice in recent years have become so acute that the majority of doctors are now open to teamwork, to working with colleagues with other skills, be it nurses or pharmacists, to provide joined up healthcare, but without everything having to be done by the doctor."

Of course, IT will be an important part in the success of the new contract. And while Mr Towne is confident that the equipment and software will be there, "one of the sticking points has been the reluctance of GP colleagues to share the patient record", said Dr Fradd. "Surely this new pharmacist contract can only work if the whole NHS family has access to that patient record?"

Dr Chisholm argued that the culture needs to change. "In the past, GPs have seen themselves as custodians of the life-long patient record and then there have been other records about patients elsewhere in the health service, in hospitals or in health visitor's records, or in pharmacy records. But they haven't previously been joined up, and if we're actually talking about greater co-operation and teamwork in how care is provided, then we have to move to sharing information better.

"This will open up the possibility of different professionals contributing to a single record that can be accessed appropriately. That does need a public and professional debate because some GPs will be a little nervous. I think that some patients will be a little nervous too and we need to understand how the NHS care record is going to be constructed and used and who has access to it, because if people don't have confidence in the confidentiality and security of that system, then people are going to be reluctant to use it.

"So there is a real issue about the need for a wide-ranging public debate so that people can move forward with their eyes open, knowing that this is a system that will produce better care for patients, which is what it's all about."

Left, inset, the CR-Rom is easy to follow. Below, Steven Williams, who believes the use of checking technicians will increase

The use of checking technicians is something that I think we'll see increase

The round table discussion was sponsored by UniChem, System Solutions Ltd and GlaxoSmithKline plus+.

Classifiedads

Appointments £27.00 P.S.C.C. + VAT minimum 3x1.
General classified £18.00 P.S.C.C. + VAT minimum 3x2.
Box Numbers £15.00 extra. Available on request. Copy date noon Tuesday prior to Saturday publication.
Cancellation deadline 10am Friday; one week prior to insertion date. All cancellations must be in writing.
Contact Debra Thackeray, Chemist & Druggist (Classified), CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW. Telephone 01732 377493, Fax: 01732 377179. Internet: http://www.dotpharmacy.com

All major credit cards accepted

Appointments

Appointments

Moss Pharmacy
Dispenser (full or p/t) - Hemel Hempstead

Exciting opportunity for qualified or trainee dispenser to support branch team based in Hemel Hempstead. Working for one of the UK's largest pharmacy chains you will recieve a competitive salary and flexible benefits package.

For more information, or to apply, please contact Debbie Roberts 01954 233464 or email debbie.roberts@mosspharmacy.co.uk

P/T QUALIFIED DISPENSING ASSISTANT

Required (or aiming towards qualification)
- Must be self-motivated
- Some Counter duties will be required
- Pleasant working enviroment
- Ask for Sam on:

0208-539-5984 or 07956460703

Businesses for sale

THINKING OF SELLING!!

We have purchasers ready and willing to pay top prices for good quality pharmacies in:

London, Home Counties and the Midlands areas.

Guaranteed total discretion and confidentiality

Please call Anne **NOW** *for a* ***free*** *valuation.*

Hutchings Consultants Ltd
01494 722224

email: info@hutchingsandco.com

www.pharmacyexperts.com

Buying a pharmacy?

Ease the cash flow pains of starting up.

FastFlow for Pharmacy enables you to receive immediate payment for your NHS dispensing.

Contact Andy on Freephone:
0808 144 5554
or E-mail: info@resourcepartners.com
Web: www.resourcepartners.com

resource

#685

Businesses wanted

Selling your Pharmacy? We would like to buy

Day Lewis is a privately owned chain with over 100 outlets.

If you are **thinking of selling** we are keen to purchase leasehold or freehold

Call Tony Hough on 020 8689 2255 ext 221 or mobile 07740 878836 All enquiries treated in strictest confidence

Day Lewis House, 324 Bensham Lane, Thornton Heath, Surrey CR7 7EQ
Email: tonyhough@daylewisplc.com Fax 020 8689 0076
www.daylewisplc.com

DAY LEWIS

Adam Myers
For all your healthcare needs

A small group looking to acquire shops in the Midlands, covering Gloucestershire, Herefordshire, Shropshire, Staffordshire, Warwickshire, Worcestershire and surrounding areas.
All turnovers considered, all information treated with strictest confidence and a high premium paid.
For a quick decision please contact Mr Bhandal on 07710 574890
E-mail: csb@adammyers.co.uk

Chemicare Health

READY TO SELL?

Chemicare Health Ltd
are acquiring substantial
Community Pharmacies in and around
the North West of England.

We pride ourselves in preserving the Community based environment you have worked hard to build and we are ready to pay you generously for that.

Interested? Please call and see if we can do business.
David Turner 01744 830334
07779 791714

Raylane Ltd
1985 20 yrs 2005
Group of Pharmacies

Is seeking to Purchase existing Pharmacies in the following counties:

Gloucestershire, Herefordshire, Warwickshire, Worcestershire, Staffordshire and surrounding areas

Please Contact: Dinesh (Danny) Patel on 07968 851331

All discussions will be treated with absolute confidence.
All turnovers will be considered, should the existing pharmacy meet our criteria, We guarantee a high premium.

Courses

Buttercups Training Ltd

BUTTERCUPS
ACCREDITED TRAINING PROVIDER

Membership of The Buttercups Academy now available!

Modular CPD for Medicine Counter Assistants and Pharmacy Technicians

For a fast and friendly response, our team is waiting to help!
e-mail: training@buttercups.co.uk
web: www.buttercups.co.uk
or tel: 0115 9374936

BUTTERCUPS TRAINING LTD.
FAIRWAY, BACK LANE,
NORMANTON ON THE WOLDS
NOTTINGHAM
NG12 5NP

INVESTOR IN PEOPLE

City & Guilds

FREE LEGAL ADVICE

Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm. The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@cmpinformation.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

Shopfitting

Planning a re-fit? Adding a new consulting room?

Why go into debt with all the pressures of repayments and security?
Use the alternative source of funding that's designed for growing pharmacy businesses.

Contact Andy on Freephone:
0808 144 5554
or E-mail: info@resourcepartners.com
Web: www.resourcepartners.com

resource partners

Tax Consultants & Accountants

ATTENTION!!!

ARE YOU PLANNING TO SELL YOUR PHARMACY IN THE NEXT 5 YEARS?

Let us help you to maximise your profits by grooming your business for future sale.

WE CAN ADVISE YOU ON:

- How to structure your business to minimise your tax bill when you sell.
- Increasing your turnover.
- Increasing your gross margin.
- Monitoring your expenses.
- Benchmarking your business against similar pharmacies.

For more information, please visit:
www.pharmacyexperts.com
or contact: **Anne Hutchings**
on: **01494 722224**

h & Co.
Facsimile: 01494 434764
Email: anne@hutchingsandco.com

Hutchings & Co.

The Leading Tax Consultants and Accountants for Pharmacists.

Want to maximise the value of your business?

Speak to the experts in exit planning and business disposal

HAZLEWOODS
CORPORATE FINANCE

- Company disposals
- Business Grooming
- Exit and Tax Planning
- Business Valuation
- Acquisitions and MBO
- Development Capital

contact: **Norman Webber** Corporate Finance and Healthcare Partner
Tel: 01242 246670 nlw@hazlewoods.co.uk
Hazlewoods Corporate Finance
Windsor House, Bayshill Road
Cheltenham GL50 3AT
www.hazlewoods.co.uk

Authorised and Regulated by the Financial Services Authority

To advertise in these pages please telephone 01732 377493

Tax Consultants & Accountants

Should you be looking for more from your accountants and tax advisers?

- Have you ever tested your current accountant? *(You can do this by visiting www.modiplus.co.uk and clicking on "test your accountant")*
- Are you looking to change your accountant or tax adviser?
- Are you fed up with paying too much tax?
- Are you paying too much for poor advice or service?
- Are you treated with indifference?

If your answers to these questions are mainly YES, you need our services urgently. Call Umesh or Jay for more information or for a FREE consultation on the numbers below:

CHARTERED ACCOUNTANTS

modiplus
ADDING VALUE

LONDON: Umesh 020 7433 1513
MANCHESTER: Jay 0161 980 0770
www.modiplus.co.uk
THE ONLY REGULATED FIRM OF CHARTERED ACCOUNTANTS AND TAX ADVISERS SPECIALISING IN RETAIL PHARMACIES

Sangers nurse **wins** **stoma** care title

Salts Healthcare has awarded its Nurse of the Year title to Jean Roberts (pictured above).

The award recognises an individual's lifetime contribution to stoma care, and Ms Roberts was considered a worthy winner by the judges for her "level of dedication and commitment".

Her interest in stoma care started when she was nursing at Royal Victoria Hospital, Belfast, and she spoke at many events to raise awareness. She later joined Belfast-based pharmaceutical wholesaler Sangers for the last 10 years of her career, before retiring two years ago.

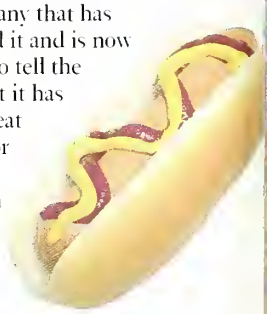
Ms Roberts said she was thrilled to have won the award, adding: "It was hard work in the early days as I was constantly having to break new ground and battle against reluctance to change. The ward sisters did as much as they could for the patients at the time, but they did not have specialist knowledge of stoma care and I wanted to fill the gap. Determination to prevent patients suffering drove me on."

Sausages at the **cutting** edge?

An e-mail in our inbox flagging up an "SSI press release" and referring to "TROPOS" would normally suggest something clinical. You know, news perhaps about the 'Treatment Of Peripheral Osteoporosis' study and some new class of drug (serum serotonin inhibitors?).

But no, the e-mail had a rather unexpected opening line: "Sausage makers have always enjoyed a special place in the nation's heart."

It turns out that in this case TROPOS is an IT system (is that what "solution" means in current parlance?) developed to help improve efficiency in manufacturing processes. SSI is the company that has developed it and is now wanting to tell the world that it has been a great success for James T Blakeman & Co Limited, "one of the UK's largest independently-owned sausage makers".



Who says we're only interested in pharmacy?

Ap o n m nt

Lindsey Fairbrother

Chris Barton

Lindsey Fairbrother has been promoted to group ethical commercial manager of United Co-op Healthcare. Since joining the company as a pharmacist in 1995, Ms Fairbrother has taken on increasingly senior management roles. Her responsibilities in her new position will include developing procurement strategies for all ethical and surgical products.

In addition, **Chris Barton** has joined United Co-op Healthcare as logistics and distribution manager. His remit includes importing branded ethical products from the European Community. Mr Barton has over 20 years' experience at senior level within distribution.

Congratulations to Lisa Stephens, winner of January's C&D Cambridge Counterpart prize draw and recipient of a bottle of bubbly from course sponsor Wyeth Consumer Healthcare. Lisa has worked at the Cox & Robinson (Chemists) branch in Queensway, Bletchley near Milton Keynes, for just under a year, and is thinking about undertaking a dispensing course if her geography and biology A level workload allows. For more information on the Cambridge Counterpart counter assistant training course contact Mary Prebble on 01732 377269

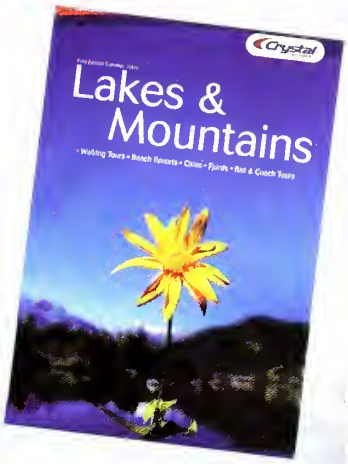
pharmacy**travel**

EXCLUSIVE OFFERS

CRYSTAL LAKES & MOUNTAINS HOLIDAYS

GREAT VALUE HOLIDAYS IN BEAUTIFUL SETTINGS WITH EXCEPTIONAL COST SAVINGS

- **£100 per couple discount on selected May and June holidays**
- **7% discount on all other holidays**



f beautiful scenery and fresh mountain air appeals, a **Crystal Lakes & Mountains** holiday is definitely for you! The programme eatures the most beautiful regions of Europe nd North America and there is something for veryone – whether you are looking for an active walking and sightseeing holiday or just a relaxing reak in tranquil surroundings. There are over 00 resorts to choose from in more than a dozen ountries including Austria, Canada, France, Norway, Italy, Switzerland and USA.

Reservations/information: 0870 242 6239

www.crystalholidays.co.uk

Terms, conditions and booking deadlines apply.
Exclusive offers are subject to availability and may be restricted to selected dates, locations etc.
Bookings must be made through Pharmacy Travel.

LOW COST TRAVEL INSURANCE

ou can take advantage of this great travel insurance offer whether or not you book a holiday through Pharmacy Travel.

- **Single trip European cover from only 60p per day***
- **Single trip Worldwide cover from only £1.20 per day***
- **Annual European cover from only £25***
- **Annual Worldwide cover from only £30***

olicyholders receive free subscription to holidaysaver, a unique package of benefits, savings and privileges esigned to save you even more money. No other travel insurance service offers low premiums plus all these ree extra holiday benefits.

- **Excellent benefits – unbeatable rates**
- **Price match and premium refund guarantees**
- **Comprehensive cover or medical expenses only**
- **Locum cover included under cancellation/curtailment sections**
- **Guaranteed discounts on every holiday booking**
- **Free worldwide emergency medical assistance and free pre-travel advice**
- **Free car parking at UK airports and free overseas car hire for the first 24-hours of every trip**
- **Commission free travel money**
- **Discounts on airport VIP lounge passes, travel publications/guidebooks, uggage/accessories, ski-wear, photo-processing and much more**

Cover level B – excluding Insurance Premium Tax

harmacy Travel is a service provided by Travel Clubs International – authorised and egulated by the Financial Services Authority for the sale of travel insurance

holiday saver

Pharmacy Travel guarantees year-round savings

A combination of generous discounts and exclusive offers always ensures excellent cost savings on:

- ✓ Activity holidays
- ✓ Airport hotels
- ✓ Airport car parking
- ✓ All-inclusive resorts
- ✓ Beach clubs
- ✓ British holidays
- ✓ Camping holidays
- ✓ Car hire
- ✓ City breaks
- ✓ Coach holidays
- ✓ Country house hotels
- ✓ Cruises
- ✓ Escorted tours
- ✓ Farmhouses & gites
- ✓ Flights
- ✓ Fly-drive holidays
- ✓ Golfing breaks
- ✓ Health spas
- ✓ Hotel bookings
- ✓ Independent travel
- ✓ Motoring holidays
- ✓ Package holidays
- ✓ Sailing & boating holidays
- ✓ Short breaks
- ✓ Ski holidays
- ✓ Theatre breaks
- ✓ Travel insurance
- ✓ Villas and apartments

For further information call Pharmacy Travel

0870 242 6239

ABTA
55821

Vitality for Your Mind, Body & SALES

Centrum Performance is a complete multivitamin with minerals for adults, which includes two natural herb extracts.

* Trade M